The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Monday, February 1, 2016
TIME: 1:30—3:30 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 132** Grimsley (Similar CS/CS/H 37)	Direct Primary Care; Specifying that a direct primary care agreement does not constitute insurance and is not subject to provisions relating to prepaid limited health service organizations and discount medical plan organizations, or any other chapter of the Florida Insurance Code; providing that certain certificates of authority and licenses are not required to market, sell, or offer to sell a direct primary care agreement, etc. HP 02/01/2016 Fav/CS BI FP	Fav/CS Yeas 9 Nays 0
2	**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 HP 02/01/2016 Temporarily Postponed AHS AP	Temporarily Postponed
3	**SB 620** Grimsley (Similar CS/H 315)	Medical Examiners; Providing that a member of the public may not be charged for certain examinations, investigations, or autopsies; authorizing a county to charge a medical examiner approval fee under certain circumstances, etc. HP 02/01/2016 Favorable CA FP	Favorable Yeas 8 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 662** Brandes (Compare H 957, Linked S 664)	Public Records/Clearinghouse for Compassionate and Palliative Care Plans/AHCA ; Creating an exemption from public records for identifying information in compassionate and palliative care plans filed with the clearinghouse for compassionate and palliative care plans at the Agency for Health Care Administration; authorizing the disclosure of certain information to certain entities and individuals; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity, etc. HP 02/01/2016 Fav/CS GO AP	Fav/CS Yeas 7 Nays 1
5	**SB 664** Brandes (Compare H 957, Linked S 662)	Physician Orders for Life-sustaining Treatment; Requiring the Department of Health to develop, and adopt by rule, a physician order for life-sustaining treatment (POLST) form; requiring the Agency for Health Care Administration to act as the state clearinghouse for compassionate and palliative care plans and information on those plans; authorizing a hospice care team to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; requiring the Department of Health to establish circumstances and procedures for honoring a POLST form; requiring a health care surrogate to provide written consent for a POLST form under certain circumstances, etc. HP 02/01/2016 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 1
6	**SB 964** Grimsley (Identical CS/H 313)	Prescription Drug Monitoring Program; Providing that certain acts of dispensing controlled substances in specified facilities are not required to be reported to the prescription drug monitoring program, etc. HP 02/01/2016 Fav/CS CJ FP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1082** Latvala (Similar H 973)	Evaluation of Students with Impairing Conditions Who are Preparing for Licensure as Health Care Practitioners or Veterinarians; Creating the hardship evaluation program for students with financial hardships who are preparing for licensure as health care practitioners or veterinarians and who are referred to an impaired practitioners program; providing for the submission of invoices to the Department of Health by consultants and for the payment of evaluators directly by the department, etc. HP 02/01/2016 Favorable AHS AP	Favorable Yeas 9 Nays 0
8	**CS/SB 1084** Banking and Insurance / Gaetz (Compare H 963, S 210)	Health Care Protocols; Citing this act as the "Right Medicine Right Time Act"; requiring a managed care plan, an insurer, and a health maintenance organization to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term “fail-first protocol”; prohibiting a health maintenance organization from requiring that a health care provider use a clinical decision support system or a laboratory benefits management program in certain circumstances, etc. BI 01/19/2016 Fav/CS HP 02/01/2016 Favorable AP	Favorable Yeas 9 Nays 0
9	**SB 1144** Gaetz	Certificates of Need for Health Care-related Projects; Providing an exemption from certificate of need review for certain health care-related projects; specifying conditions and requirements for the exemption; requiring a certain agreement between the project applicant and the Agency for Health Care Administration; providing penalties for failure to comply with certain requirements for an exemption to a certificate of need review, etc. HP 02/01/2016 Favorable AHS AP	Favorable Yeas 6 Nays 3
10	**SB 1378** Garcia (Identical H 1329)	Drug Safety; Requiring pharmacies to offer for sale prescription lock boxes; requiring the Department of Health to develop and distribute a pamphlet; prohibiting a pharmacy from charging a fee for the pamphlet, etc. HP 02/01/2016 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
11	**SB 1442** Garcia (Compare CS/H 221)	Out-of-network Health Insurance Coverage; Requiring hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with certain provisions as a condition of licensure; adding a ground for discipline of referring health care providers by the Department of Health; revising the methodology for determining health maintenance organization reimbursement amounts for emergency services and care provided by certain providers, etc. HP 02/01/2016 Fav/CS BI AP	Fav/CS Yeas 5 Nays 4
12	**SB 1504** Bean (Compare CS/H 941, CS/S 918)	Credit for Relevant Military Service; Providing for the issuance of a license to practice under certain conditions to a military health care practitioner in a profession for which licensure in a state or jurisdiction is not required to practice in the military; requiring the Construction Industry Licensing Board and the Electrical Contractors' Licensing Board to provide a method by which honorably discharged veterans may apply for licensure, etc. HP 01/26/2016 Temporarily Postponed HP 02/01/2016 Favorable AGG AP	Favorable Yeas 9 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 132
INTRODUCER:	Health Policy Committee and Senators Grimsley and Gaetz
SUBJECT:	Direct Primary Care
DATE:	February 1, 2016
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 132 provides that a direct primary care agreement is not insurance and is not subject to the Florida Insurance Code. Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. Through a contractual agreement, a patient pays a monthly fee to the primary care provider for defined primary care services. The bill specifies certain provisions that must be included in a direct primary care agreement.

II. Present Situation:

Direct Primary Care

Direct primary care is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. Through a contractual agreement, a patient pays a monthly fee, usually between $50 and $100 per individual,[1] to the primary care provider for defined primary care services, such as access to the patient's primary care provider 24/7. Other primary care services may include:

- Office visits;
- Annual physical examination;

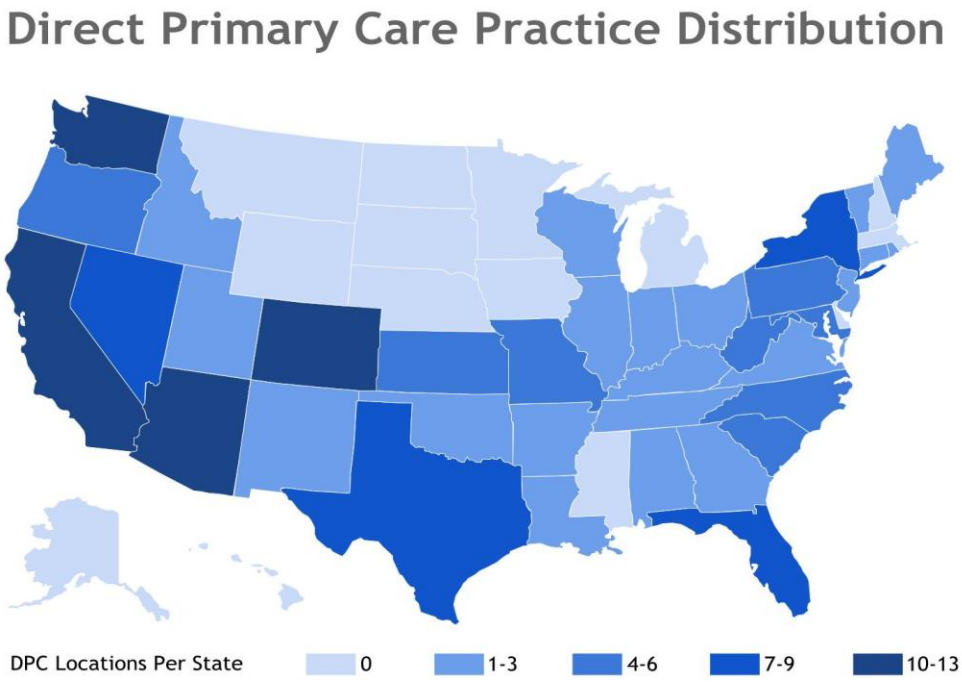
[1] Approximately two thirds of DPC practices charge less than $135 per month. Jen Wieczner, *Is Obamacare Driving Doctors to Refuse Insurance?,* WALL ST. J. MARKETWATCH, Nov. 12, 2013 *available at* http://www.marketwatch.com/story/is-direct-primary-care-for-you-2013-11-12 (last visited Jan. 27, 2016).

- Routine laboratory tests;
- Vaccinations;
- Wound care;
- Splinting or casting of fractured or broken bones;
- Other routine testing, e.g. echocardiogram and colon cancer screening; or
- Other medically necessary primary care procedures.

After paying the fee, a patient can access all services under the agreement at no extra charge. Some DPC practices also include routine preventative services, like lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address the large majority of health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

In the DPC practice model, the primary care provider eliminates practice overhead costs associated with filing claims, coding, refiling claims, write-offs, appealing denials, and employing billing staff. The cost and time savings can be reinvested in the practice, allowing more time with patients to address their primary care needs.

The following chart illustrates the concentration of DPC practices in the United States:[2]



In 2014, the American Academy of Private Physicians (AAPP) estimated that approximately 5,500 physicians operate under some type of direct financial relationship with their patients,

[2] Jay Keese, Executive Director, Direct Primary Care Coalition, *Direct Primary Care*, PowerPoint presentation before the House Health Innovation Subcommittee (Feb. 17, 2015), slide 4, *available at* http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2859&Session=2015&DocumentType=Meeting Packets&FileName=his 2-17-15.pdf (last visited Jan. 27, 2016).

outside of standard insurance coverage.[3] The AAPP said that number has increased around 25 percent per year since 2010.[4]

DPC and Health Care Reform

The Patient Protection and Affordable Care Act (PPACA)[5] addresses the DPC practice model as part of health care reform. A qualified health plan under PPACA is permitted to offer coverage through a DPC medical home plan if it provides essential health benefits and meets all other criteria in the law.[6] Patients who are enrolled in a DPC medical home plan are exempt from the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy to cover treatment for serious illnesses, like cancer, or severe injuries that require lengthy hospital stays and rehabilitation.[7] In Colorado and Washington, qualified health plans are offering DPC medical home coverage on each state-based health insurance exchange.[8]

III. Effect of Proposed Changes:

The bill creates s. 624.27. F.S., relating to the application of the Florida Insurance Code (code) to direct primary care agreements. Several new definitions are created under this section:

- *Direct primary care agreement* means a contract between a primary care provider and a patient, the patient's legal representative, or an employer which must satisfy certain requirements within the bill and does not indemnify for services provided by a third party.
- *Primary care provider* means a licensed health care practitioner under chapter 458 (medical doctor or physician assistant), chapter 459 (osteopathic doctor or physician assistant), chapter 460 (chiropractic physician), or chapter 464 (nurses), or a primary care group practice who provides medical services which are commonly provided without referral from another health care provider.
- *Primary care service* means the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

The bill provides that a direct primary care agreement is not insurance and entering into such an agreement is not the business of insurance. The bill exempts both the agreement and the activity from the code. Through the exemption, the bill eliminates any authority of OIR to regulate a direct primary care agreement or the act of entering into such an agreement. The bill also exempts a primary care provider, or his or her agent, from certification or licensing requirements under the code to market, sell, or offer to sell a direct primary care agreement.

The bill requires a direct primary care agreement to:

- Be in writing;

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[3] David Twiddy, *Practice Transformation: Taking the Direct Primary Care Route*, FAMILY PRACTICE MGMT, No. 3, (May-June 2014), http://www.aafp.org/fpm/2014/0500/p10.html (last visited Jan. 27, 2016).
[4] Id.
[5] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).
[6] 42 U.S.C. §1802 (a)(3); 45 C.F.R. §156.245.
[7] 42 U.S.C. §18021(a)(3).
[8] Robleto, *Supra* note 1, slide 2.

- Be signed by the primary care provider, or his or her agent, and the patient, or the patient's legal representative, or an employer;
- Allow either party to terminate the agreement by written notice followed by a waiting period as specified in the agreement;
- Describe the scope of services that are covered by the monthly fee;
- Specify the monthly fee and any fees for primary care services not covered by the monthly fee;
- Specify the duration of the agreement and any automatic renewal provisions;
- Provide for a refund to the patient of monthly fees paid in advance if the primary care provider stops offering primary care services for any reason;
- State that the agreement is not health insurance and the primary care provider will not file any claims against any health insurance or reimbursement plans the patient may have for any primary care services covered by the agreement; and
- State that the agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the federal Patient Protection and Affordable Care Act.

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:

CS/SB 132 also removes regulatory uncertainty for health care providers as to whether the direct primary care agreement is insurance. Additional primary care providers may elect to pursue this option and establish direct primary care practices in this state which could increase access to affordable primary care services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 624.27 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 1, 2016:
The CS expands the definition of a primary care provider to include a chiropractic physician and conforms the description of the licensed persons to health care practitioners as opposed to health care providers.

B. Amendments:

None.

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

762054

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/01/2016	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 30 - 34
and insert:
(b) "Primary care provider" means a health care practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 464, or a primary care group practice that provides medical services to patients which are commonly provided without referral from another health care provider.

By Senator Grimsley

21-00052-16 2016132__

A bill to be entitled

An act relating to direct primary care; creating s. 624.27, F.S.; defining terms; specifying that a direct primary care agreement does not constitute insurance and is not subject to ch. 636, F.S., relating to prepaid limited health service organizations and discount medical plan organizations, or any other chapter of the Florida Insurance Code; specifying that entering into a direct primary care agreement does not constitute the business of insurance and is not subject to ch. 636, F.S., or any other chapter of the code; providing that certain certificates of authority and licenses are not required to market, sell, or offer to sell a direct primary care agreement; specifying requirements for a direct primary care agreement; providing an effective date.

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

Section 1. Section 624.27, Florida Statutes, is created to read:

624.27 Application of code as to direct primary care agreements.—

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

(a) "Direct primary care agreement" means a contract between a primary care provider and a patient, the patient's legal representative, or an employer which meets the requirements specified under subsection (4) and does not indemnify for services provided by a third party.

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

21-00052-16 2016132__

(b) "Primary care provider" means a health care provider licensed under chapter 458, chapter 459, or chapter 464, or a primary care group practice that provides medical services to patients which are commonly provided without referral from another health care provider.

(c) "Primary care service" means the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

(2) A direct primary care agreement does not constitute insurance and is not subject to chapter 636 or any other chapter of the Florida Insurance Code. The act of entering into a direct primary care agreement does not constitute the business of insurance and is not subject to chapter 636 or any other chapter of the Florida Insurance Code.

(3) A primary care provider or an agent of a primary care provider is not required to obtain a certificate of authority or license under chapter 636 or any other chapter of the Florida Insurance Code to market, sell, or offer to sell a direct primary care agreement.

(4) For purposes of this section, a direct primary care agreement must:

(a) Be in writing.

(b) Be signed by the primary care provider or an agent of the primary care provider and the patient, the patient's legal representative, or an employer.

(c) Allow a party to terminate the agreement by written notice to the other party after a period specified in the agreement.

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

(d) Describe the scope of primary care services that are covered by the monthly fee.

(e) Specify the monthly fee and any fees for primary care services not covered by the monthly fee.

(f) Specify the duration of the agreement and any automatic renewal provisions.

(g) Offer a refund to the patient of monthly fees paid in advance if the primary care provider ceases to offer primary care services for any reason.

(h) State that the agreement is not health insurance and that the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement for any primary care services covered by the agreement.

(i) State that the agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act pursuant to 26 U.S.C. s. 5000A.

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

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: September 21, 2015

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

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

132
Bill Number (if applicable)

762054
Amendment Barcode (if applicable)

Topic _____

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: ☐ For ☐ Against ☐ Information

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

Representing Florida Chiropractic Asso.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

SB 132
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Jeff Scott

Job Title _____

Address 1430 Piedmont Dr. E.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850 251 2439

Email jscott@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

132
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nland

Job Title _____

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

Phone 904-233-3051

Email nlandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-2016
Meeting Date

SB 132
Bill Number (if applicable)

Topic DIRECT PRIMARY CARE

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

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

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

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16 [redacted]
Meeting Date

132
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Tim Nungesser

Job Title Legislative Director

Address 110 E. Jefferson St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-445-5367

Email tim.nungesser@nfib.org

Speaking: ☒ For ☐ Against ☐ Information

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

Representing NFIB

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/2016
Meeting Date

SB 82
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Melissa Fause

Job Title Policy Analyst

Address 200 W. College Ave, Ste. 109
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-408-1218

Email MFause@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-Feb-16
Meeting Date

SB 132
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Direct Primary Care

Name Catherine Boer

Job Title Chair

Address 1421 Woodgate Way
Street

Tallahassee FL 32308
City *State* *Zip*

Phone

Email

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

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

Representing The Tea Party Network

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

SB 132
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Diane Gowski, MD

Job Title MD | physician

Address 1383 Temple St
Street

Phone 727-480-2574

Clearwater FL 33756
City *State* *Zip*

Email dianetg@aol.com

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

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

Representing Florida Chapter of AAPS (American Association of Physicians & Surgeons)

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

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.

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[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.

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

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

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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

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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

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 620
INTRODUCER:	Senator Grimsley
SUBJECT:	Medical Examiners
DATE:	January 28, 2016
REVISED:	

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

I. Summary:

SB 620 restricts counties and district medical examiners from charging a fee for an examination, investigation, or autopsy to determine the cause of death of a decedent except that the bill allows counties, by resolution or ordinance, to charge a fee of up to $50 for the medical examiner's approval of the cremation, burial at sea, or dissection of a body. The county may not charge this fee if the death falls under the jurisdiction of the medical examiner and involves certain suspicious circumstances.

II. Present Situation:

Medical Examiners Act

Part I of ch. 406, F.S., is titled the "Medical Examiners Act"[1] (act) and lays out minimum and uniform requirements for statewide medical examiner services. Among other things, the act establishes the Medical Examiners Commission[2] (commission) with duties including initiating cooperative policies with any agencies of the state; investigating, suspending, and removing medical examiners for violations of the act; overseeing the distribution of state funds for the medical examiner districts; and making any necessary agreements and contracts in order to effect the provisions of the act, subject to the approval of the executive director of the Florida Department of Law Enforcement (FDLE).[3] The act also requires the commission to establish medical examiner districts each of which is served by a medical examiner who is appointed by the Governor.[4] Currently, there are 24 medical examiner districts.[5]

[1] Section 406.01, F.S.
[2] The Medical Examiners Commission consists of seven members appointed by the Governor, one member appointed by the State Attorney General, and one member appointed by the State Surgeon General.
[3] Section 406.02, F.S.
[4] Sections 406.05 and 406.06, F.S.
[5] Florida Medical Examiner Districts, *available at* http://myfloridamedicalexaminer.com/ (last visited on Jan. 26, 2016).

Section 406.11(1), F.S., requires district medical examiners to determine the cause of death of a decedent who died or was found dead in their district:

- If the person died:
  - Of criminal violence;
  - By accident;
  - By suicide;
  - Suddenly, when in apparent good health;
  - Unattended by a practicing physician or other recognized practitioner;
  - In any prison or penal institution;
  - In police custody;
  - In any suspicious or unusual circumstance;
  - By criminal abortion;
  - By poison;
  - By disease constituting a threat to public health; or
  - By disease, injury, or toxic agent resulting from employment.
- If the dead body was brought into the state without proper medical certification; or
- If the dead body is to be cremated, dissected, or buried at sea.[6,7]

Subsections (1) and (2)(a) of s. 406.11, F.S., require and grant authority to the medical examiner to make or have performed any examinations, investigations, and autopsies they deem necessary or that are requested by the state attorney for the purpose of determining the cause of death. Subsection (2) also restricts the medical examiners from retaining or furnishing any body part for any purpose other than those authorized in statute[8] without notifying the next of kin and grant rulemaking authority to the commission to adopt rules for such notifications. Subsection (3) grants the commission rulemaking authority to incorporate practice parameters for medical examiners.

Medical Examiner Fees

Section 406.06(3), F.S., entitles district and associate medical examiners to "compensation and such reasonable salary and fees as are established by the board of county commissioners in the respective districts." Presently, as required in s. 406.08, F.S., district medical examiners submit an annual budget to the board of county commissioners which includes fees, salaries, and expenses for their office. Medical examiner office budgets that are established through contract

[6] The medical examiner must approve the cremation of a dead body through a consent process that differs from one district to another. Some medical examiner districts require written consent while others may allow telephone approval. Approval will not be written in the death record margin or in such a way as to deface the record. See Vital Records Registration Handbook, February 2015 Revision, p. 67, *available at* http://www.floridahealth.gov/certificates/certificates/_documents/HB2015v2.pdf (last visited on Jan. 26, 2016).

[7] In 2014, 44,540 dead bodies were buried, 116,642 were cremated, 1,547 were donated, and 11 were buried at sea. See Florida Death Count Query System, *available at* http://www.floridacharts.com/FLQUERY/Death/DeathCount.aspx (last visited on Jan. 26, 2016).

[8] In ch. 406, F.S., relating to medical examiners and the disposition of human remains; Part V of ch. 765, F.S., relating to the granting of anatomical gifts; and ch. 873, F.S., relating to the sale of anatomical matter.

with county governments[9] are often based on a fee-for-service schedule.[10] Each specific fee is approved by the board of county commissioners in each county within the district, and the fee may vary from county to county. In some districts, fees for a specific type of service are paid directly to the medical examiner's office, while in other districts, such fees go directly to the county's general revenue fund.[11] The fees charged by district medical examiner's offices for the services provided pursuant to s. 406.11, F.S., vary from district to district. For example, according to the Medical Examiners Commission, for cremation services three districts (14, 20, and 22) charge no fee while the other 21 districts fees vary with district 11 (Miami-Dade County) charging the highest fee at $63. Other than district 11, only district 17 (Broward County with a $54 charge) charges fees higher than $50.[12] The total amount of revenue generated by cremation service fees in 2014 was approximately $3.98 million.[13]

III. Effect of Proposed Changes:

SB 620 amends s. 382.011, F.S., to restrict counties and district medical examiners from charging members of the public a fee for an examination, investigation, or autopsy performed to determine the cause of death involving circumstances listed in s. 406.11(1), F.S. Notwithstanding the restriction, the bill allows counties, by resolution or ordinance, to charge a fee of up to $50 for medical examiner approval for the cremation, burial at sea, or dissection of a body so long as the death is not under the jurisdiction of the medical examiner involving circumstances listed in s. 406.11(1)(a), F.S. The bill also makes other technical and conforming changes to clarify that the list for when a medical examiner must determine a person's cause of death is based on the circumstances surrounding the death, rather than the causes or conditions of the death.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, subsection 18(a) of the Florida Constitution, provides that a county or municipality may not be bound by any general law requiring the county or municipality to spend funds or to take an action requiring the expenditure of funds, unless the Legislature has determined that such law fulfills an important state interest and unless:

- Funds have been appropriated that have been estimated at the time of enactment to be sufficient to fund such expenditure;
- The Legislature authorizes or has authorized a county or municipality to enact a funding source not available for such county or municipality on February 1, 1989, that can be used to generate the amount of funds estimated to be sufficient to fund such expenditure by a simple majority vote of the governing body of such county or municipality;

[9] Medical examiner services are provided by private contract in districts 1, 2, 5, 6, 8, 10, 12, 14, 16, 20, 21, and 22. See Revised FDLE bill analysis for HB 315 (2015), December 14, 2015, (on file with the Senate Committee on Health Policy).
[10] Id.
[11] Supra note 9
[12] Supra note 9
[13] Supra note 9

- The law requiring such expenditure is approved by two-thirds of the membership in each house of the Legislature;
- The expenditure is required to comply with a law that applies to all persons similarly situated, including the state and local governments; or
- The law is either required to comply with a federal requirement or required for eligibility for a federal entitlement, which federal requirement specifically contemplates actions by counties or municipalities for compliance.

Subsection 18(d) provides an exemption from this prohibition. Laws determined to have an "insignificant fiscal impact," which means an amount not greater than the average statewide population for the applicable fiscal year times 10 cents (which is $1.98 million for 2015-2016 fiscal year), are exempt.

SB 620 will likely have only and insignificant fiscal impact on local government revenue and therefore will not require a two-thirds vote.

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:

SB 620 may have a positive fiscal impact on those in the private sector who would have been charged a fee that is reduced or prohibited by the bill.

C. Government Sector Impact:

Local governments may incur a loss in revenue if they currently charge fees to cover costs of operations which would be reduced or prohibited by the changes in the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 382.011 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

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

By Senator Grimsley

21-00634-16 2016620__

A bill to be entitled

An act relating to medical examiners; amending s. 382.011, F.S.; providing that a member of the public may not be charged for certain examinations, investigations, or autopsies; authorizing a county to charge a medical examiner approval fee under certain circumstances; providing an effective date.

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

Section 1. Subsection (1) of section 382.011, Florida Statutes, is amended to read:

382.011 Medical examiner determination of cause of death.—

(1) In the case of any death or fetal death involving the circumstances ~~due to causes or conditions~~ listed in s. 406.11(1) ~~s. 406.11~~, any death that occurred more than 12 months after the decedent was last treated by a primary or attending physician as defined in s. 382.008(3), or any death for which there is reason to believe that the death may have been due to an unlawful act or neglect, the funeral director or other person to whose attention the death may come shall refer the case to the district medical examiner of the county in which the death occurred or the body was found for investigation and determination of the cause of death. A county or district medical examiner may not charge a member of the public a fee for an examination, investigation, or autopsy performed to determine the cause of death involving the circumstances listed in s. 406.11(1). However, a county, by resolution or ordinance of the board of county commissioners, may charge a member of the public

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

21-00634-16 2016620__

a fee for medical examiner approval not to exceed $50 when a body is to be cremated, buried at sea, or dissected, provided the fee is not charged for a death under the jurisdiction of the medical examiner when such death involves the circumstances listed in s. 406.11(1)(a).

Section 2. This act shall take effect October 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: November 17, 2015

I respectfully request that **Senate Bill #580**, relating to Reimbursement to Health Access Settings for Dental Hygiene Services, and **Senate Bill #620** relating to Medical Examiners be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

SB 620
Bill Number (if applicable)

Topic Medical Examiners

Amendment Barcode (if applicable)

Name JAMES WYLIE

Job Title

Address 5359 Pembridge Place
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 850-567-1705

Email JAMESWYLIEE gmail.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Funeral Cemetery & Consumer Advocacy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

620
Bill Number (if applicable)

Topic DEATH TAX REPEAL

Amendment Barcode (if applicable)

Name JERRY PAUL

Job Title

Address
Street

Phone 850-386-5267

City *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing "TRUST 100"

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

SB 620
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Jeff Scott

Job Title _____

Address 1430 Piedmont Dr. E
Street

Tallahasree FL 32308
City *State* *Zip*

Phone 850 251-2439

Email jscott@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

620
Bill Number (if applicable)

Topic MEDICAL EXAMINERS

Amendment Barcode (if applicable)

Name JACK McRAY

Job Title

Address 200 W. COLLEGE ST. #304
Street

Phone 850-577-5187

TLH FL 32301
City *State* *Zip*

Email jmcray@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/1/2016 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 620

Meeting Date *Bill Number (if applicable)*

Topic Medical Examiner *Amendment Barcode (if applicable)*

Name Georgia McKeown

Job Title President, GA McKeown & Assoc

Address 113 E. College Ave #303 Phone 904 303 1611

Street

Tallahassee FL 32301 Email georgia@gamckeown.com

City *State* *Zip*

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

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

Representing Florida Cemetery, Cremation & Funeral 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)

2/1/16
Meeting Date

620
Bill Number (if applicable)

Topic Medical Examiners

Amendment Barcode (if applicable)

Name Daphnee Sainvil

Job Title Lobbyist

Address 115 S. Andrews Ave, Rm. 426 Phone 954-253-7320
Street

Ft. Lauderdale FL 33301 Email dsainvil@broward.org
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Broward County

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

620
Bill Number (if applicable)

Topic Medical Examiners

Amendment Barcode (if applicable)

Name Richard Pinsky

Job Title

Address 106 E. College Ave. #1200
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 Miami-Dade County

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)
2/6	620

Amendment Barcode (if applicable)

Topic _____

Name JESS McCARTY

Job Title _____

Address 111 NW 1ST ST 2810 (Street)

Phone 305-979-7110

MIAMI 33128 (City / State / Zip)

Email JMM2@MIAMIDADE.GOV

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against

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

Representing MIAMI-DADE COUNTY

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 662
INTRODUCER:	Health Policy Committee and Senator Brandes
SUBJECT:	Public Records/Clearinghouse for Compassionate and Palliative Care Plans/AHCA
DATE:	February 1, 2016
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 662 creates an exemption from the public record requirements for compassionate and palliative care plans held by the Agency for Health Care Administration (AHCA) or its designee. The bill permits disclosure of such information only after verification of the request and the requestor's identity. Disclosure is permitted to a physician or health care facility for treatment purposes and to the patient or his or her representative.

The bill takes effect on July 1, 2016, contingent upon SB 664 or similar language taking effect.

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

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

II. Present Situation:

The Florida Constitution provides that the public has the right to access government records and meetings. The public may inspect or copy any record made or received in connection with the official business of any public body, officer, or employee received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their

behalf.[1] The public also has a right to be afforded notice and access to meetings of any collegial public body of the executive branch of state government or of any local government.[2] The Legislature's meetings must also be open and noticed to the public, unless there is an exception provided for by the Constitution.[3]

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

> It is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is the duty of each agency.[4]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[5] A violation of the Public Records Act may result in civil or criminal liability.[6]

Section 286.011, Florida Statutes, the "Sunshine Law,"[7] requires all meetings of any board or commission or local agency or authority at which official acts are to be taken to be noticed and open to the public.[8]

The Legislature may, by two-thirds votes of the House and the Senate[9] create an exemption to public records or open meetings requirements.[10] An exemption must explicitly state the public

[1] FLA. CONST., art. 1, s. 24(a).
[2] FLA. CONST., art. 1, s. 24(b).
[3] FLA. CONST., art. 1, s. 24 (b).
[4] Chapter 119, F.S.
[5] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of their physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purpose of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency." The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). The Legislature's records are public pursuant to section 11.0431, F.S.
[6] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are penalties for violations of those laws.
[7] *Board of Public Instruction of Broward County v. Doran*, 224 So. 2d 693, 695 (Fla. 1969).
[8] Section 286.011(1)-(2), F.S. The Sunshine Law does not apply to the Legislature; rather, open meetings requirements for the Legislature are set out in the Florida Constitution, Article III, s. 4(e) of the Florida Constitution provides the legislative committee meetings must be open and noticed to the public. In addition, prearranged gatherings, between more than two members of the Legislature, or between the Governor, the President of the Senate, or the Speaker of the House of Representatives, the purpose of which is to agree upon or to take formal legislative action, must be reasonable open to the public.
[9] FLA. CONST., art. I, s. 24(c).
[10] FLA. CONST., art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates as *confidential* and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons

necessity of the exemption[11] and must be tailored to accomplish the stated purpose of the law.[12] A statutory exemption which does not meet these two criteria may be found unconstitutional, and efforts may not be made by the court to preserve the exemption.[13]

Open Government Sunset Review Act

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

The OGSR prescribes a legislative review process for newly created or substantially amended public records.[14] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[15] In practice, many exemptions are continued by repealing the sunset date rather than reenacting the exemption.

Under the OGSR the purpose and necessity of reenacting the exemption are reviewed. The Legislature must consider the following questions during its review of an exemption:[16]

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

If the Legislature expands an exemption, then a public necessity statement and a two-thirds vote for passage are required.[17] If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are

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or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole,* 874 So.2d 48 (Fla. 5th DCA 2004).

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

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

[13] *Halifax Hosp. Medical Center v. News-Journal Corp.,* 724 So.2d 567 (Fla. 1999). In *Halifax Hospital,* the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. In *Baker County Press, Inc. v. Baker County Medical Services, Inc.,* 870 So. 2d 189 (Fla. 1st DCA 2004), the court found that the intent of a statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional.

[14] Section 119.15, F.S. According to s. 119.15(4)(b), F.S., a substantially amended exemption is one that is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to s. 119.15(2), F.S. The OGSR process is currently being followed; however, the Legislature is not required to continue to do so. The Florida Supreme Court has found that one legislature cannot bind a future legislature. *Scott v. Williams,* 107 So. 3d 379 (Fla. 2013).

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

[16] Section 119.15(6)(a), F.S.

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

not required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless otherwise provided for by law.[18]

Clearinghouse for Compassionate and Palliative Care Plans

Through a linked bill, CS/SB 664, the Agency for Health Care Administration (AHCA) or its designee is responsible for establishing and maintaining a reliable and secure database that will allow Florida residents to electronically submit their individual plans for compassionate and palliative care. The database must be accessible to health care providers who are treating the resident.

The AHCA is directed to seek input on the clearinghouse from state residents, compassionate and palliative care providers, and health care facilities for its development and implementation. The AHCA may also subscribe to or participate in a national or private clearinghouse that will accomplish the same goals in lieu of establishing an independent clearinghouse. Once clearinghouse information is available, the AHCA is required to publish and disseminate information regarding the availability of the clearinghouse to Floridians. The AHCA must also provide training to health care providers and health care facilities on how to access plans.

The POLST form, along with other health care advance directive forms, that will be submitted to the Clearinghouse will contain personal identifying information of patients, identifying information of patient family members, health care status information, proposed treatment plans, and end-of-life plans.

III. Effect of Proposed Changes:

Section 1 creates section 408.0641, F.S., to make information held in the clearinghouse for compassionate and palliative care plans held at the AHCA or its designee confidential and exempt from public disclosure under s. 119.07(1), F.S. and s. 24(a), Art. I of the State Constitution.

The AHCA or its designee is permitted to disclose confidential and exempt information to the following persons after using a verification process to ensure the legitimacy of the request and the requestor's identity for individuals who have a plan in the clearinghouse:

- A physician who certifies that the information is necessary to provide medical treatment to a patient with a terminal illness;
- A patient or the legal guardian or designated health care surrogate of a patient with a terminal illness; or
- A health care facility that certifies that the information is necessary to provide medical treatment to a patient with a terminal illness.

The bill provides, as required by the State Constitution, a statement of public necessity which states that disclosure of the specified information:

- Could invade the personal privacy of the patient or his or her family;

[18] Section 119.15(7), F.S.

- Could hinder the effective and efficient administration of the clearinghouse for compassionate and palliative care plans;
- Could reduce participation and minimize the effectiveness of compassionate and palliative care plans to meet the needs of individuals; and
- Could be used to solicit, harass, stalk, or intimidate clearinghouse participants or terminally ill patients or their families.

The bill further states that information held in the clearinghouse which would identify patients or which contains or reflects a patient's medical information should be confidential and exempt from public records requirements.

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

The bill takes effect on the same date that SB 664[19] or similar legislation takes effect if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement

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

Public Necessity Statement

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

C. Trust Funds Restrictions:

None.

[19] Senate Bill 664 has an effective date of July 1, 2016.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector providers may experience administrative expenses in accessing the clearinghouse for information on patients.

C. Government Sector Impact:

The Agency for Health Care Administration (AHCA) estimates the costs for the Clearinghouse for Compassionate and Palliative Care Plans to be $350,000 for the first year of implementation and $140,000 per year for maintenance costs to participate in a national or private clearinghouse.[20]

VI. Technical Deficiencies:

None

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 408.0641 of the Florida Statutes:

IX. Additional Information:

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

CS by Health Policy on February 1, 2016:
The CS extends the public records exemption to the AHCA's designee as well to the AHCA in the event the AHCA elects to subscribe to or participate in a database operated by a public or private clearinghouse as authorized in the substantive bill (SB 664).

B. Amendments:

None.

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

[20] Agency for Health Care Administration, *Senate Bill 1052 Analysis* (Feb. 20, 2015), p. 4, (on file with Senate Committee on Health Policy).

234508

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/01/2016	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 408.0641, Florida Statutes, is created to read:

408.0641 Clearinghouse for compassionate and palliative care plans; public records exemption.—

(1) Information held in the clearinghouse for compassionate and palliative care plans at the Agency for Health Care

Administration or its designee under s. 408.064 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) The agency or its designee may disclose such confidential and exempt information to the following persons or entities upon request after using a verification process to ensure the legitimacy of the request and the requestor's identity:

(a) A physician who certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

(b) A patient or the legal guardian or designated health care surrogate of a patient with a terminal illness who has a plan in the clearinghouse.

(c) A health care facility that certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

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

Section 2. The Legislature finds that it is a public necessity to make confidential and exempt from disclosure information held in the clearinghouse for compassionate and palliative care plans which would identify a patient, his or her terminal illness, or the patient's family members. Such personal identifying information, if publicly available, could be used to invade the personal privacy of the patient or his or her family.

234508

The decisions made under a compassionate and palliative care plan for a terminal condition are a private matter. Furthermore, the public disclosure of such information could hinder the effective and efficient administration of the clearinghouse for compassionate and palliative care plans. Public access to such information could reduce participation and minimize the effectiveness of compassionate and palliative care plans to meet the needs of individuals. Finally, access to such information could be used to solicit, harass, stalk, or intimidate clearinghouse participants or terminally ill patients or their families. Therefore, the Legislature finds that information held in the clearinghouse for compassionate and palliative care plans which would identify a patient participating in the clearinghouse or which contains or reflects the patient's medical information should be confidential and exempt from public records requirements.

Section 3. This act shall take effect on the same date that SB 664 or similar legislation takes effect if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to public records; creating s. 408.0641, F.S.; creating an exemption from public records for identifying information in compassionate

234508

and palliative care plans filed with the clearinghouse for compassionate and palliative care plans at the Agency for Health Care Administration or its designee; authorizing the disclosure of certain information to certain entities and individuals; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing a contingent effective date.

By Senator Brandes

22-00685-16 2016662__

A bill to be entitled

An act relating to public records; creating s. 408.0641, F.S.; creating an exemption from public records for identifying information in compassionate and palliative care plans filed with the clearinghouse for compassionate and palliative care plans at the Agency for Health Care Administration; authorizing the disclosure of certain information to certain entities and individuals; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 408.0641, Florida Statutes, is created to read:

408.0641 Clearinghouse for compassionate and palliative care plans; public records exemption.—

(1) Information held in the clearinghouse for compassionate and palliative care plans at the Agency for Health Care Administration under s. 408.064 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) The agency may disclose such confidential and exempt information to the following persons or entities upon request after using a verification process to ensure the legitimacy of the request and the requestor's identity:

(a) A physician who certifies that the information is

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

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necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

(b) A patient or the legal guardian or designated health care surrogate of a patient with a terminal illness who has a plan in the clearinghouse.

(c) A health care facility that certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

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

Section 2. The Legislature finds that it is a public necessity to make confidential and exempt from disclosure information held in the clearinghouse for compassionate and palliative care plans which would identify a patient, his or her terminal illness, or the patient's family members. Such personal identifying information, if publicly available, could be used to invade the personal privacy of the patient or his or her family. The decisions made under a compassionate and palliative care plan for a terminal condition are a private matter. Furthermore, the public disclosure of such information could hinder the effective and efficient administration of the clearinghouse for compassionate and palliative care plans. Public access to such information could reduce participation and minimize the effectiveness of compassionate and palliative care plans to meet the needs of individuals. Finally, access to such information could be used to solicit, harass, stalk, or intimidate

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

clearinghouse participants or terminally ill patients or their families. Therefore, the Legislature finds that information held in the clearinghouse for compassionate and palliative care plans which would identify a patient participating in the clearinghouse or which contains or reflects the patient's medical information should be confidential and exempt from public records requirements.

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

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 21, 2016

I respectfully request that **Senate Bill #662**, relating to **Public Records/Clearinghouse for Compassionate and Palliative Care Plans/AHCA**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 22

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 664
INTRODUCER:	Health Policy Committee and Senator Brandes
SUBJECT:	Physician Orders for Life-sustaining Treatment
DATE:	February 2, 2016 REVISED:

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

I. Summary:

CS/SB 664 recognizes a Physician Order for Life Sustaining Treatment (POLST) and establishes a Clearinghouse for Compassionate and Palliative Care Plans for state residents as a central registry for advance directives for health care. The Agency for Health Care Administration (AHCA) is directed to establish and maintain the site, either independently or through a national or private clearinghouse. Plans are required to be electronically accessible. The AHCA is also directed to disseminate information about the clearinghouse once available.

The bill also provides requirements for the contents of the POLST form and its proper execution. The Department of Health (DOH) is required to develop the form by rule.

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

II. Present Situation:

End of Life Decision-Making

There are a number of different advanced decision making documents an individual may use to express his or her end of life health care decisions. In Florida, state law defines advance directives as witnessed, oral statements or written instructions that express a person's desires about any aspect of his or her future health care, including the designation of a health care surrogate, a living will, or an anatomical gift.[1]

Resuscitation may also be withheld from an individual if a "do not resuscitate" order (DNRO) by the patient's physician is presented to the health care professional treating the patient. For the DNRO to be valid, it must be on the form adopted by the DOH, signed by the patient's physician

[1] *See* s. 765.101, F.S.

and by the patient, or if the patient is incapacitated, the patient's health care surrogate or proxy, court-appointed guardian, or attorney in fact under a durable power of attorney.[2] Florida's DNRO form is printed on yellow paper.[3] It is the responsibility of the Emergency Medical Services provider to ensure that the DNRO form or the patient identification device, which is a miniature version of the form, accompanies the patient.[4] A DNRO may be revoked by the patient at any time, if signed by the patient, or the patient's health care surrogate, proxy, court-appointed guardian or a person acting under a durable power of attorney.[5]

A Physician Order for Life-Sustaining Treatment (POLST) documents a patient's health care wishes in the form of a physician order for a variety of end of life measures, including cardiopulmonary resuscitation (CPR).[6] A DNRO is limited to the withholding of CPR. The POLST form can only be completed by a physician and is then provided to the patient to be kept secured in a visible location for emergency personnel.[7] It is suggested that the form be completed when an individual has a serious illness, regardless of age, as the POLST serves as a medical order for a current illness.[8]

Some questions asked on other states' POLST forms include what level of care is wanted for CPR (attempt or do not attempt); medical intervention (comfort only, limited additional intervention, or full treatment); and artificially administered nutrition (none, trial, or long-term). At least 16 other states have implemented or endorsed a POLST program, with Oregon and West Virginia being cited as having mature programs.[9]

In comparison to a POLST, an advance directive's purpose is to give instructions on the appointment of a health care representative, express intentions for future treatment or health care, or for an anatomical gift.[10] Florida law allows such advance directives to be expressed in writing or by orally designating another person to make health care decisions upon that person's incapacity.[11]

A living will is another mechanism used by individuals to express life-prolonging wishes through a written document or a witnessed oral statement.[12] Any competent adult may make a living will or written declaration, at any given time, to address the providing, withholding, or withdrawing of life-prolonging procedures should that individual have a terminal or end-stage condition.[13] A living will requires the signature of the individual in the presence of two witnesses, one of whom is not the spouse nor a blood relative. It becomes the individual's

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[2] *See* ss. 395.1041, 400.142, 400.487, 400.605, 400.6095, 401.35, 401.45, 429.255, 429.73, and 7665.205, F.S.
[3] Rule 64J-2.018, F.A.C.
[4] Id.
[5] Id.
[6] POLST.ORG, *About the National POLST Paradigm*, http://www.polst.org/about-the-national-polst-paradigm/ (last visited Jan. 27, 2016).
[7] POLST.ORG, *FAQ*, http://www.polst.org/advance-care-planning/faq/ (last visited Jan. 27, 2016).
[8] POLST.ORG, *POLST v. Advance Directives*, http://www.polst.org/advance-care-planning/polst-and-advance-directives/ (last visited Jan. 27, 2016).
[9] POLST.ORG, *Programs in Your State*, http://www.polst.org/programs-in-your-state/ (last visited Jan. 26, 2016).
[10] *See* s. 765.101, F.S.
[11] *See* s. 765.101(2), F.S.
[12] *See* s. 765.101(13), F.S.
[13] Section 765.302, F.S.

responsibility to notify health care providers about the living will, so it can be made a part of the individual's medical record.

Starting January 1, 2016, advance care planning (ACP) services from physicians and other health care professionals will be available as a separate billed service covered by Medicare.[14] If a Medicare beneficiary wants to discuss advance care planning during his or her annual wellness visit, physicians and other health care professionals may provide the service during the visit and bill Medicare separately for it. Such services can be provided in both facility and non-facility settings. Previous to this date, ACP services could only billed as part of another visit; it could not be the sole reason for the physician visit.[15]

Clearinghouse for Compassionate and Palliative Care Plans

In addition to the availability of the POLST form, several states also have registries for the collection of advance directives. In 2012, West Virginia created the WV e-Directive Registry which makes advance directives, DNROs, POLSTs, living wills, and medical powers of attorney available online 24/7 to health care practitioners and facilities when the individual specifically opts in to the registry.[16] Almost 100 hospitals, nursing homes, home care agencies, and private practice health care professionals have access to the WV e-Registry.[17]

Oregon released its first POLST form in 1995.[18] An individual is not required to send a completed POLST form to the registry. If an individual does not want his or her form in the registry, the Oregon POLST form contains an "opt-out" box that can be checked.[19] When a POLST form is submitted to the registry by the primary care physician, the individual receives a confirmation letter in return, a magnet, and a set of stickers with their registry identification number for future access.[20] The number is to be given to the individual's primary care physician and the magnet and stickers put in prominent places, including something the person might usually carry with them. The registry is overseen by the Oregon Health Authority.[21]

Idaho's Health Care Directives Registry is offered through its Secretary of State's office. Individuals may submit several types of health care directive documents, including a Physician Order for Scope of Treatment (POST) form, living will, or durable power of attorney for health care.[22] Documents can be submitted online to the Secretary of State or via the mail. Once

[14] 42 CFR 410.15.
[15] Henry J. Kaiser Family Foundation, *10 FAQs: Medicare's Role in End of Life Care*, http://kff.org/medicare/fact-sheet/10-faqs-medicares-role-in-end-of-life-care/ (last visited Jan. 27, 2016).
[16] West Virginia Center for End-of-Life Care, *e-Directive Registry*, http://www.wvendoflife.org/resources-links/e-directive-registry/ (last visited Jan. 27, 2016).
[17] Id.
[18] POLST Oregon, http://www.or.polst.org/history (last visited Jan. 27, 2016).
[19] POLST Oregon, http://www.or.polst.org/registry-resources (last visited Jan. 27, 2016).
[20] Id.
[21] The Oregon Health Authority is responsible for most state health services. It is overseen by a nine-member citizen Oregon Health Policy Board. *For more see:* http://www.oregon.gov/oha/Pages/index.aspx
[22] Idaho Secretary of State, *Health Care Directive Registry*, http://www.sos.idaho.gov/GENERAL/hcdr.html (last visited Jan. 27, 2016).

registration is confirmed, individuals receive a wallet sized registration card with an individualized filing number and password and information about using the registry.[23]

New York utilizes a secure web-based application for its electronic Medical Orders for Life-Sustaining Treating (eMOLST) forms. The forms can be printed for the medical record and then stored and linked to the electronic eMOLST registry. The forms can be accessed by emergency medical services, hospitals, nursing homes, and most all health care providers in the community via the online portal.[24] The eMOLST form may also be used for minor patients.[25]

III. Effect of Proposed Changes:

Physician Orders for Life-Sustaining Treatment (POLST) Program (Section 1)

The bill creates s. 401.451, F.S., the Physician Order for Life-Sustaining Treatment program, within the DOH. The DOH is directed to implement and administer the program and to collaborate with the AHCA on the implementation and operation of the Clearinghouse for Compassionate and Palliative Care plans.

Under s. 401.451, F.S., definitions are provided for the following terms:

- "Advance directive" means the same as in s. 765.101, F.S.;[26]
- "Agency" means the Agency for Health Care Administration;
- "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" means the same as in s. 408.064, F.S.;[27]
- "Compassionate and palliative care plan" or "plan" means the same as in s. 408.064, F.S.;[28]
- "Do-not-resuscitate order" means an order issued pursuant to s. 401.45(3), F.S.;
- "End-stage condition" means the same as in s. 765.101, F.S.;[29]
- "Examining physician" means a physician licensed under ch. 458, F.S., or ch. 459, F.S., who examines a patient who wishes, or whose legal representative wishes, to execute a POLST form; who attests to the patient's or the patient's representative's ability to make and communicate health care decisions; who signs the POLST form; and who attests to the patient's execution of the POLST form;

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[23] Id.

[24] eMOLST - Electronic Medical Orders for Life Sustaining Treatment in New York State, *available at* http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/emolst (last visited Jan. 27, 2016).

[25] Medical Orders for Life Sustaining Treatment - Professionals (FAQS), *available at* http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/frequently_asked_questions/molst_faqs_page_1 (last visited Jan. 27, 2016).

[26] "Advance directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of ch. 765, F.S.

[27] "Compassionate and palliative care plans" means the state's electronic database of compassionate and palliative care plans submitted by residents of this state and managed by the agency pursuant to s. 408.064, F.S.

[28] "Compassionate and palliative care plan" means any end-of-life document or medical care directive document recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, a do-not-resuscitate order, a physician order for life-sustaining treatment, or a health care surrogate designation.

[29] "End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

- "Legal representative" means a patient's legally authorized health care surrogate or proxy as provided in ch. 765, F.S., a patient's court-appointed guardian as provided in ch. 744, F.S., an attorney in fact, or a patient's parent if the patient is a minor; and
- "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to s. 401.451, F.S., which specifies a patient with an end stage condition and provides directives for that patient's medical treatment under certain conditions.

The bill establishes specific duties for the DOH for the POLST program. These duties include the requirement to:

- Adopt rules to implement and administer the POLST program;
- Prescribe a standardized POLST form;
- Provide the POLST form in an electronic format on the DOH's website and prominently state the requirements for a POLST form;
- Consult with health care professional licensing groups, provider advocacy groups, medical ethicists, and other appropriate stakeholders on the development of rules and forms;
- Collaborate with the AHCA to develop and maintain the clearinghouse;
- Ensure that the DOH staff receive ongoing training on the POLST program and the availability of POLST forms;
- Recommend a statewide, uniform process through which a patient that has executed a POLST form is identified and the health care providers currently treating the patient are provided with contact information for the examining physician who signed the POLST form;
- Adopt POLST-related continuing education requirements for health care providers licensed by the DOH; and
- Develop a process for collecting provider feedback to facilitate the periodic re-design of the POLST form with current health care best practices.

POLST Form (Section 1)

The form must be voluntarily executed by the patient, or if the patient is incapacitated, by the patient's legal representative at the time of signing the form. To be valid, the POLST form must meet all of the following requirements:

- Be printed on one or both sides of a single piece of paper in a solid color, which may be white, as determined by the DOH rule;
- Include the signatures of the patient and the patient's examining physician or, if the patient is incapacitated, the patient's legal representative and the patient's examining physician, executed after consultation with the patient or the patient's legal representative as appropriate;
- Indicate prominently that completion of the form is voluntary, the use of the form is not a condition of any treatment, and the form cannot be given any affect if the patient is conscious and competent to make health care decisions;
- Prominently provide in a conspicuous location on the form a space for the examining physician to attest and affirm that, in his or her good faith clinical judgment, at the time the POLST form is completed and signed, the patient has the ability to make and communicate health care decisions or, if the patient is incapacitated, that the patient's legal representative has such an ability;

- Provide an expiration date that is within 1 year after the patient or the patient's legal representative signs the form or that is contingent on the completion of the course of treatment addressed in the POLST form, whichever occurs first;
- Identify the medical condition or conditions that necessitate the POLST form; and
- Not include a directive regarding hydration or the preselection of any decisions or directives.

The POLST form may only be used by a patient whose examining physician has determined that the patient has an end-stage condition or who, in the good faith clinical judgment of the examining physician, is suffering from at least one life-limiting medical condition that will likely result in the death of the patient within 1 year.

At a minimum, the patient's physician must review the POLST form with the patient or the patient's representative, when the patient:

- Is transferred from one health care setting or level of care to another;
- Is discharged from a health care setting to return home before the expiration of the POLST form;
- Experiences a substantial change in his or her condition as determined by the patient's examining physician, in which case the review must occur within 24 hours of the substantial change; or
- Expresses an intent to change his or her treatment preferences.

A POLST form may be revoked at any time by a patient, or if the patient is incapacitated and the authority to revoke a POLST form has been granted by the patient to his or her legal representative, the patient's legal representative. The execution of a POLST form by a patient and his or her examining physician under this section automatically revokes any prior POLST form previously executed by the patient.

If a family member of the patient, the health care facility providing the services to the patient, or the patient's physician who may reasonably be expected to be affected by the patient's POLST form directives believes the directives are in conflict with the patient's prior expressed desires regarding end-of-life care, he or she or the facility may seek expedited judicial intervention pursuant to the Florida Probate Rules.

If the directives on a patient's POLST form conflict with another advance directive of the patient that address a substantially similar health care condition or treatment, the document most recently signed by the patient takes precedence. Such directives may include, but are not limited to:

- Living wills;
- Health care powers of attorney;
- POLST forms for the specific medical condition of treatment; or
- Do-not-resuscitate orders.

Any licensee, physician, medical director, emergency medical technician, or paramedic who in good faith complies with a POLST form is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct as a result of carrying out the

directives of a POLST form. A person, acting in good faith as a legal representative, is not subject to civil liability or criminal prosecution for executing a POLST form pursuant to this law.

If medical orders on a POLST form are carried out to withhold life-sustaining treatment for a minor, the order must include certification by one health care provider in addition to the physician executing the POLST form that the order is in the best interest of the minor patient. A POLST form for a minor patient must also be signed by the minor patient's legal representative. The minor patient's physician must certify the basis for the authority of the minor patient's legal representative to execute the POLST form, including his or her compliance with the relevant statutory provisions of ch. 765, F.S., relating to health care advance directives and ch. 744, F.S., relating to guardianship.

The bill further requires that when a patient who has executed a valid POLST form is transferred from one health care facility to another, the health care facility initiating the transfer must communicate the existence of the POLST form to the receiving facility before the transfer. Upon the patient's transfer, the receiving facility's treating physician must review the POLST form with the patient or if the patient is incapacitated, the patient's legal representative.

Facilities and providers may not require a person to complete, revise, or revoke a POLST as a prerequisite or condition of receiving services or treatment or as a condition of admission. The execution, revision, or revocation of a POLST form must be a voluntary decision of the patient.

The presence or absence of a POLST form does not affect, impair, or modify a contract of life or health insurance or annuity to which an individual is a party and may not serve as the basis for any delay in issuing or refusing to issue an annuity or policy of life or health insurance or for an increase or decrease in premiums charged to an individual.

A POLST form is invalid if payment or other remuneration was offered or made in exchange for its execution.

The act may not be construed to condone, authorize, or approve mercy killing or euthanasia. A statement of legislative intent provides that this act is not to be construed as permitting any affirmative or deliberate act to end a person's life, except to permit the natural process of dying.

Clearinghouse for Compassionate and Palliative Care Plans (Section 2)

Section 2 creates s. 408.064, F.S., which establishes the Clearinghouse for Compassionate and Palliative Care Plans within the AHCA. The AHCA is responsible for establishing and maintaining the clearinghouse directly or through a designee. The clearinghouse must be a reliable and secure database that will allow Florida residents to electronically submit their individual plans for compassionate and palliative care. The database may only be accessed by a health care provider who is treating the resident.

As used in this section, the bill provides definitions for these terms:

- "Advance directive" means the same as in s. 765.101, F.S.;[30]
- "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" means the state's electronic database of compassionate and palliative care plans submitted by residents of this state and managed by the agency pursuant to this section;
- "Compassionate and palliative care plan" or "plan" means any end-of-life document or medical directive document recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, a do-not-resuscitate order, a physician order for life-sustaining treatment, or a health care surrogate designation;
- "Department" means the Department of Health;
- "Do-not-resuscitate order" means an order issued pursuant to s. 401.45(3), F.S.;
- "End-stage condition" means the same as in s. 765.101, F.S.;[31] and
- "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to s. 401.451, F.S., which specifies the care and medical treatment under certain medical conditions for a patient with an end stage conditions.

By January 1, 2017, the AHCA is required to establish and maintain a reliable and secure database consisting of compassionate and palliative care plans submitted by state residents which is accessible to health care providers through a secure portal. The database must allow for electronic submission, storage, indexing, and retrieval of plans by treating health care providers. The AHCA must also develop and maintain an identity validation system that confirms the identity of the facility, health care provider, or other authorized individual seeking retrieval of plans while protecting the privacy of patient's personal and medical information. The system must meet all applicable state and federal privacy and security standards.

The AHCA is directed to seek input on the clearinghouse from state residents, compassionate and palliative care providers, and health care facilities for its development and implementation. The AHCA may subscribe to or participate in a national or private clearinghouse that will accomplish the same goals in lieu of establishing an independent clearinghouse. Once clearinghouse information is available, the AHCA is required to publish and disseminate information regarding the availability of the clearinghouse to Floridians. The AHCA must also provide training to health care providers and health care facilities on how to access plans.

Statutory Revisions to Include POLST (Sections 3-10 and 12)

Provisions in statute requiring health professional staff to honor "do not resuscitate" orders (DNROs) are revised to include recognition of a POLST document in the same manner.

The table below reflects the statutes impacted by these revisions.

[30] "Advance directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of ch. 765, F.S.

[31] "End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

Statutory Revisions - Addition of POLST Language	
F.S. Citation	**Description**
§400.142	Nursing Homes; Emergency medication kits; DNROs
§400.487	Home Health Service Agreements; DNROs
§400.605	Hospices; Administration; forms; fees
§400.6095	Hospice; patient admission; assessment; plan of care; discharge; death
§401.35	Medical Transportation Services: Rules
§401.45	Denial of emergency treatment; civil liability
§429.255	Assisted Living Facilities; Use of personnel; emergency care
§429.73	Rules and standards relating to adult family-care homes
§456.072	Grounds for discipline; penalties; enforcement
§765.205	Responsibility of the surrogate

Section 11 - amends s. 456.072, F.S., relating to discipline for health care practitioners generally, to allow a licensee to withhold or withdraw cardiopulmonary resuscitation (CPR) or the use of an automated external defibrillator if presented with an order not to resuscitate or a POLST which includes a DNRO. The DOH is directed to adopt rules for the implementation of such orders. Additionally, the bill provides that licensees who withhold CPR or the use of an automated external defibrillator may not be subject to criminal prosecution and may not be considered to have acted in a negligent or unprofessional manner for carrying out DNRO or POLST orders.

The bill further provides that the absence of an order [not] to resuscitate pursuant to s. 408.064, F.S., or a POLST form executed pursuant to s. 408.064, F.S., does not preclude a licensee from withholding or withdrawing CPR or the use of an external automated defibrillator or otherwise carrying out medical orders allowed by law.

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:

A separate public records exemption bill for the Clearinghouse for Compassionate and Palliative Care Plans (SB 662) is linked to this bill to ensure the information contained on the POLST forms is kept confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. The POLST forms contain sensitive medical information and personal identifying information.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Potentially, a private sector vendor would be selected to operate the Clearinghouse for Compassionate and Palliative Care Plans. The AHCA estimates the fiscal impact to the state for this contract for implementation to be $350,000 for the first year and $140,000 for maintenance costs to participate in a national or private clearinghouse.[32]

Patients might request their providers complete and submit POLST forms on their behalf to the clearinghouse, which could increase a provider's administrative costs.

C. Government Sector Impact:

The AHCA estimates the costs for the Clearinghouse for Compassionate and Palliative Care Plans to be $350,000 for the first year of implementation and $140,000 per year for maintenance costs to participate in a national or private clearinghouse.[33]

The AHCA also requests 1.00 FTE to administer the project from planning and procurement through implementation and to direct statewide outreach and education activities for residents and providers. For the first year, the AHCA requests $67,045 and then $62,518 recurring annually for the position.[34]

The DOH estimates minimal fiscal impact relating to rule development for the POLST form and orders not to resuscitate pursuant to a POLST form.[35] The DOH indicates these costs can be absorbed within existing resources.[36]

The Department of Elderly Affairs (DOEA) estimates a minimal fiscal impact related to rulemaking for implementation of the POLST forms at hospices, assisted living facilities, and adult family day cares.[37] The DOEA indicates these costs can be absorbed within existing resources.[38]

VI. Technical Deficiencies:

[32] Agency for Health Care Administration, *Senate Bill 664 Analysis,* p. 5-6, (Feb. 2, 2016) (on file with the Senate Committee on Health Policy).
[33] Id.
[34] Id.
[35] Department of Health, *Senate Bill 664 Analysis,* p. 3 (Oct. 30, 2015) (on file with the Senate Committee on Health Policy).
[36] Id at 4.
[37] Department of Elderly Affairs, *Senate Bill 664 Analysis,* p. 2 (Dec. 15, 2015) (on file with the Senate Committee on Health Policy).
[38] Id at 4.

CS/SB 664 does not amend s. 395.1041, F.S., to protect hospital personnel for honoring a POLST form as the filed bill, SB 664, did. This appears to be an oversight.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.142, 400.487, 400.605, 400.6095, 401.35, 401.45, 429.255, 429.73, 456.072, and 765.205.

This bill creates the following sections of the Florida Statutes: 401.451 and 408.064.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

CS by Health Policy on February 1, 2016:
The CS created a separate statutory section for the POLST form distinct from the registry and modified the program's requirements by:

- Adding an expiration date to the form;
- Including identification of the medical condition(s) that necessitate the form;
- Specifying additional components for usage by minor patients;
- Providing for periodic review of the form; and
- Allowing for revocation.

The CS also identified specific program responsibilities for the Department of Health to:

- Collaborate with others to develop rules and forms;
- Adopt continuing education requirements for licensed health practitioners and develop training for the DOH staff on the POLST program; and
- Recommend a statewide uniform process for identifying patients and health care providers who signed the POLST form.

B. Amendments:

None.

802432

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/01/2016	.	
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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 401.451, Florida Statutes, is created to read:

401.451 Physician Orders for Life-Sustaining Treatment Program.—The Physician Orders for Life-Sustaining Treatment Program is established within the Department of Health to implement and administer the development and use of physician

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orders for life-sustaining treatment consistent with this section and to collaborate with the Agency for Health Care Administration in the implementation and operation of the Clearinghouse for Compassionate and Palliative Care Plans created under s. 408.064.

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

(a) "Advance directive" has the same meaning as in s. 765.101.

(b) "Agency" means the Agency for Health Care Administration.

(c) "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" has the same meaning as in s. 408.064.

(d) "Compassionate and palliative care plan" or "plan" has the same meaning as in s. 408.064.

(e) "Do-not-resuscitate order" means an order issued under s. 401.45(3).

(f) "End-stage condition" has the same meaning as in s. 765.101.

(g) "Examining physician" means a physician licensed under chapter 458 or chapter 459 who examines a patient who wishes, or whose legal representative wishes, to execute a POLST form; who attests to the patient's, or the patient's representative's, ability to make and communicate health care decisions; who signs the POLST form; and who attests to the patient's execution of the POLST form.

(h) "Legal representative" means a patient's legally authorized health care surrogate or proxy as provided in chapter 765, a patient's court-appointed guardian as provided in chapter 744, an attorney in fact, or a patient's parent if the patient

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is a minor.

(i) "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to this section which specifies a patient with an end-stage condition and provides directives for that patient's medical treatment under certain conditions.

(2) DUTIES OF THE DEPARTMENT.—The department shall:

(a) Adopt rules to implement and administer the POLST program.

(b) Prescribe a standardized POLST form pursuant to this section.

(c) Provide the POLST form in an electronic format on the department's website and prominently state on the website the requirements for a POLST form under paragraph (3)(a).

(d) Consult with health care professional licensing groups, provider advocacy groups, medical ethicists, and other appropriate stakeholders on the development of rules and forms.

(e) Collaborate with the agency to develop and maintain the clearinghouse.

(f) Ensure that department staff receive ongoing training on the POLST program and the availability of POLST forms.

(g) Recommend a statewide, uniform process through which a patient who has executed a POLST form is identified and the health care providers currently treating the patient are provided with contact information for the examining physician who signed the POLST form.

(h) Adopt POLST-related continuing education requirements for health care providers licensed by the department.

(i) Develop a process for collecting provider feedback to

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facilitate the periodic redesign of the POLST form in accordance with current health care best practices.

(3) POLST FORM.—

(a) *Requirements*.—A POLST form may not include directives regarding hydration or the preselection of any decisions or directives. A POLST form must be voluntarily executed by the patient or, if the patient is incapacitated, the patient's legal representative, and all directives included in the form must be made by the patient or, if the patient is incapacitated, the patient's legal representative at the time of signing the form. A POLST form is not valid and may not be included in a patient's medical records or submitted to the clearinghouse as provided in this section unless it also meets all of the following requirements:

1. Be printed on one or both sides of a single piece of paper in a solid color or on white paper as determined by department rule.

2. Include the signatures of the patient and the patient's examining physician or, if the patient is incapacitated, the patient's legal representative and the patient's examining physician, executed after consultation with the patient or the patient's legal representative as appropriate.

3. Prominently state that completion of a POLST form is voluntary, that the execution or use of a POLST form may not be required as a condition for treatment, and that a POLST form may not be given effect if the patient is conscious and competent to make health care decisions.

4. Prominently provide in a conspicuous location on the form a space for the patient's examining physician to attest and

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affirm that, in his or her good faith clinical judgment, at the time the POLST form is completed and signed, the patient has the ability to make and communicate health care decisions or, if the patient is incapacitated, that the patient's legal representative has such ability.

5. Provide an expiration date that is within 1 year after the patient or the patient's legal representative signs the form or that is contingent on completion of the course of treatment addressed in the POLST form, whichever occurs first.

6. Identify the medical condition or conditions that necessitate the POLST form.

(b) *Restriction on use of a POLST form.*—A POLST form may be completed only by or for a patient determined by the patient's examining physician to have an end-stage condition or a patient who, in the good faith clinical judgment of the examining physician, is suffering from at least one life-limiting medical condition that will likely result in the death of the patient within 1 year.

(c) *Periodic review of a POLST form.*—At a minimum, the patient's physician must review the patient's POLST form with the patient or the patient's legal representative, as appropriate, when the patient:

1. Is transferred from one health care setting or level of care to another in accordance with subsection (6);

2. Is discharged from a health care setting to return home before the expiration of the POLST form;

3. Experiences a substantial change in his or her condition as determined by the patient's examining physician, in which case the review must occur within 24 hours of the substantial

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change; or

4. Expresses an intent to change his or her treatment preferences.

(d) *Revocation of a POLST form.*—

1. A POLST form may be revoked at any time by a patient or, if the patient is incapacitated and the authority to revoke a POLST form has been granted by the patient to his or her legal representative, the representative.

2. The execution of a POLST form by a patient and his or her examining physician under this section automatically revokes all POLST forms previously executed by the patient.

(e) *Review of legal representative's decision on a POLST form.*—If a family member of the patient, the health care facility providing services to the patient, or the patient's physician who may reasonably be expected to be affected by the patient's POLST form directives believes the directives are in conflict with the patient's prior expressed desires regarding end-of-life care, he or she or the facility may seek expedited judicial intervention pursuant to the Florida Probate Rules.

(f) *Conflicting advance directives.*—To the extent that directives made on a patient's POLST form conflict with another advance directive of the patient that addresses a substantially similar health care condition or treatment, the document most recently signed by the patient takes precedence. Such directives may include, but are not limited to:

a. Living wills.

b. Health care powers of attorney.

c. POLST forms for the specific medical condition or treatment.

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d. Do-not-resuscitate orders.

(4) ACTING IN GOOD FAITH; LIMITED IMMUNITY.—

(a) An individual acting in good faith as a legal representative under this section is not subject to civil liability or criminal prosecution for executing a POLST form as provided in this section on behalf of a patient who is incapacitated.

(b) Any licensee, physician, medical director, emergency medical technician, or paramedic who in good faith complies with a POLST form is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct as a result of carrying out the directives of a POLST form executed in accordance with this section and rules adopted by the department.

(5) POLST FORM FOR A MINOR PATIENT.—If medical orders on a POLST form executed for a minor patient direct that life-sustaining treatment may be withheld from the minor patient, the order must include certification by one health care provider in addition to the physician executing the POLST form that, in their clinical judgement, an order to withhold treatment is in the best interest of the minor patient. A POLST form for a minor patient must be signed by the minor patient’s legal representative. The minor patient’s physician must certify the basis for the authority of the minor patient’s legal representative to execute the POLST form on behalf of the minor patient, including his or her compliance with the relevant statutory provisions of chapter 765 or chapter 744.

(6) PATIENT TRANSFER; POLST FORM REVIEW REQUIRED.—If a patient whose goals and preferences for care have been entered

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in a valid POLST form is transferred from one health care facility to another, the health care facility initiating the transfer must communicate the existence of the POLST form to the receiving facility before the transfer. Upon the patient's transfer, the treating health care professional at the receiving facility must review the POLST form with the patient or, if the patient is incapacitated, the patient's legal representative.

(7) POLST FORM NOT A PREREQUISITE.—A POLST form may not be a prerequisite for receiving medical services or for admission to a facility. Facilities and providers may not require a person to complete, revise, or revoke a POLST form as a condition of receiving services or treatment or as a condition of admission. The execution, revision, or revocation of a POLST form must be a voluntary decision of the patient.

(8) INSURANCE NOT AFFECTED.—The presence or absence of a POLST form does not affect, impair, or modify a contract of life or health insurance or annuity to which an individual is a party and may not serve as the basis for any delay in issuing or refusing to issue an annuity or policy of life or health insurance or for an increase or decrease in premiums charged to the individual.

(9) INVALIDITY.—A POLST form is invalid if payment or other remuneration was offered or made in exchange for execution of the form.

(10) LEGISLATIVE INTENT.—This section may not be construed to condone, authorize, or approve mercy killing or euthanasia. The Legislature does not intend that this act be construed as permitting any affirmative or deliberate act to end a person's life, except to permit the natural process of dying.

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Section 2. Section 408.064, Florida Statutes, is created to read:

408.064 Clearinghouse for Compassionate and Palliative Care Plans.—The Clearinghouse for Compassionate and Palliative Care Plans is established within the Agency for Health Care Administration.

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

(a) "Advance directive" has the same meaning as in s. 765.101.

(b) "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" means the state's electronic database of compassionate and palliative care plans submitted by residents of this state and managed by the agency pursuant to this section.

(c) "Compassionate and palliative care plan" or "plan" means any end-of-life document or a medical directive document recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, a do-not-resuscitate order, a physician order for life-sustaining treatment, or a health care surrogate designation.

(d) "Department" means the Department of Health.

(e) "Do-not-resuscitate order" means an order issued pursuant to s. 401.45(3).

(f) "End-stage condition" has the same meaning as in s. 765.101.

(g) "Physician order for life-sustaining treatment" means an order issued pursuant to s. 401.451 which specifies the care and medical treatment under certain conditions for a patient with an end-stage condition.

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(2) ELECTRONIC DATABASE.—The agency shall:

(a) By January 1, 2017, establish and maintain a reliable and secure database consisting of compassionate and palliative care plans submitted by residents of this state which is accessible to health care providers through a secure electronic portal. The database must allow the electronic submission, storage, indexing, and retrieval of such plans, and allow access to such plans by the treating health care providers of the residents.

(b) Develop and maintain a validation system that confirms the identity of the facility, health care provider, or other authorized individual seeking the retrieval of a plan and provides privacy protections that meet all state and federal privacy and security standards for the release of a patient's personal and medical information to third parties.

(c) Consult with compassionate and palliative care providers, health care facilities, and residents of this state as necessary and appropriate to facilitate the development and implementation of the database.

(d) Publish and disseminate to residents of this state information regarding the clearinghouse.

(e) In collaboration with the department, develop and maintain a process for the submission of compassionate and palliative care plans by residents of this state or by health care providers on behalf of and at the direction of their patients for inclusion in the database.

(f) Provide training to health care providers and health care facilities in this state on how to access plans through the database.

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(3) ALTERNATIVE IMPLEMENTATION.—In lieu of developing the electronic database required by this section, the agency may subscribe to or otherwise participate in a database operated by a public or private clearinghouse if that database meets the requirements of this section. The alternative database may operate nationwide, regionally, or on a statewide basis in this state.

Section 3. Subsection (3) of section 400.142, Florida Statutes, is amended to read:

400.142 Emergency medication kits; orders not to resuscitate.—

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. Facility staff and facilities are not subject to criminal prosecution or civil liability, or considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise allowed ~~permitted~~ by law.

Section 4. Section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's, physician assistant's, and advanced registered nurse

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practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate; physician orders for life-sustaining treatment.—

(1) 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.

(2) If ~~When~~ required by ~~the provisions of~~ chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician, physician assistant, or advanced registered nurse practitioner, acting within his or her respective scope of practice, shall establish treatment orders for a patient who is to receive skilled care. The treatment orders must be signed by the physician, physician assistant, or advanced registered nurse practitioner before a claim for payment for the skilled services is submitted by the home health agency. If the claim is submitted to a managed care organization, the treatment orders must be signed within the time allowed under the provider agreement. The treatment orders shall be reviewed, as frequently as the patient's illness requires, by the physician, physician assistant, or advanced registered nurse practitioner in consultation with the home health agency.

(3) A home health agency shall arrange for supervisory

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visits by a registered nurse to the home of a patient receiving home health aide services in accordance with the patient's direction, approval, and agreement to pay the charge for the visits.

(4) Each patient has the right to be informed of and to participate in the planning of his or her care. Each patient must be provided, upon request, a copy of the plan of care established and maintained for that patient by the home health agency.

(5) If ~~When~~ nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

(6) The skilled care services provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

(7) Home health agency personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The agency shall adopt rules providing for the implementation of such orders. Home health personnel and agencies are ~~shall~~ not ~~be~~

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subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form and rules adopted by the agency.

Section 5. Paragraph (e) of subsection (1) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—

(1) The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. The department, in consultation with the agency, shall by rule establish minimum standards and procedures for a hospice pursuant to this part. The rules must include:

(e) Procedures relating to the implementation of advance ~~advanced~~ directives; physician orders for life-sustaining treatment (POLST) forms executed pursuant to s. 401.451; and do-not-resuscitate orders.

Section 6. Subsection (8) of section 400.6095, Florida Statutes, is amended to read:

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(8) The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Hospice staff are ~~shall~~ not ~~be~~ subject to criminal

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prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise allowed ~~permitted~~ by law.

Section 7. Subsection (4) of section 401.35, Florida Statutes, is amended to read:

401.35 Rules.—The department shall adopt rules, including definitions of terms, necessary to carry out the purposes of this part.

(4) The rules must establish circumstances and procedures under which emergency medical technicians and paramedics may honor orders by the patient's physician not to resuscitate executed pursuant to s. 401.45 or under a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate and the documentation and reporting requirements for handling such requests.

Section 8. Paragraph (a) of subsection (3) of section 401.45, Florida Statutes, is amended to read:

401.45 Denial of emergency treatment; civil liability.—

(3)(a) Resuscitation or other forms of medical intervention may be withheld or withdrawn from a patient by an emergency medical technician, ~~or~~ paramedic, or other health care professional if he or she is presented with evidence of a

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physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate or perform other medical intervention, as applicable, or an order not to resuscitate by the patient's physician ~~is presented to the emergency medical technician or paramedic~~. To be valid, an order not to resuscitate~~, to be valid,~~ must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

Section 9. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an

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automated external defibrillator pursuant to such an order or a POLST form and rules adopted by the department. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise allowed ~~permitted~~ by law.

Section 10. Subsection (3) of section 429.73, Florida Statutes, is amended to read:

429.73 Rules and standards relating to adult family-care homes.—

(3) The department shall adopt rules providing for the implementation of orders not to resuscitate and physician orders for life-sustaining treatment (POLST) forms executed pursuant to s. 401.451. The provider may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 which contains an order not to resuscitate. The provider is ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such orders ~~an order~~ and applicable rules.

Section 11. Present subsections (7) and (8) of section 456.072, Florida Statutes, are redesignated as subsections (8) and (9), respectively, and a new subsection (7) is added to that section, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) A licensee may withhold or withdraw cardiopulmonary

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resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Licensees are not subject to criminal prosecution or civil liability, and may not be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator or otherwise carrying out the orders in an order not to resuscitate or a POLST form pursuant to such an order or POLST form and rules adopted by the department. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a licensee from withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator or otherwise carrying out medical orders allowed by law.

Section 12. Paragraph (c) of subsection (1) of section 765.205, Florida Statutes, is amended to read:

765.205 Responsibility of the surrogate.—

(1) The surrogate, in accordance with the principal's instructions, unless such authority has been expressly limited by the principal, shall:

(c) Provide written consent using an appropriate form whenever consent is required, including a physician's order not to resuscitate or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451.

Section 13. This act shall take effect July 1, 2016.

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505 ================ T I T L E A M E N D M E N T ================
506 And the title is amended as follows:
507 Delete everything before the enacting clause
508 and insert:
509 A bill to be entitled
510 An act relating to physician orders for life-
511 sustaining treatment; creating s. 401.451, F.S.;
512 establishing the Physician Orders for Life-Sustaining
513 Treatment (POLST) Program within the Department of
514 Health; defining terms; requiring the department to
515 adopt rules to implement and administer the program;
516 requiring the department to develop and adopt by rule
517 a POLST form; providing requirements for the POLST
518 form; requiring the signature and attestation of a
519 physician on a POLST form; specifying that a POLST
520 form may not include directives regarding hydration;
521 requiring that POLST forms be voluntarily executed by
522 the patient and that all directives included in the
523 form be made at the time of the signing; providing
524 requirements for POLST forms; providing a restriction
525 on the execution of POLST forms; requiring periodic
526 review of POLST forms; providing for the revocation of
527 a POLST form; requiring the immediate review of a
528 POLST form in certain circumstances; specifying which
529 document controls when a POLST conflicts with other
530 advance directives; providing limited liability for
531 legal representatives and specified health care
532 providers acting in good faith in reliance on a POLST;

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imposing additional requirements on a POLST form executed on behalf of a minor patient in certain circumstances; requiring review of a POLST form on the transfer of the patient; prohibiting a POLST form from being required as a condition for treatment; providing that execution of a POLST form does not affect, impair, or modify certain insurance contracts; providing for the invalidity of POLST forms executed in return for payment or other remuneration; providing legislative intent; creating s. 408.064, F.S.; defining terms; requiring the Agency for Health Care Administration to establish a database of compassionate and palliative care plans by a specified date; requiring that the database be electronically accessible to health care providers; requiring that the database allow the electronic submission, storage, indexing, and retrieval of such plans, forms, and directives by residents of this state; requiring that the database comply with specified privacy and security standards; requiring the agency to consult with advisers and experts as necessary and appropriate to facilitate the development and implementation of the database; requiring the agency to publish and disseminate information on the database to the public; requiring the agency, in collaboration with the department, to develop and maintain a process for the submission of compassionate and palliative care plans by residents or by health care providers on behalf of and at the direction of their patients for inclusion

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in the database; requiring the agency to provide specified training; authorizing the agency to subscribe to or participate in a public or private clearinghouse in lieu of establishing and maintaining an independent database; amending ss. 400.142 and 400.487, F.S.; authorizing specified personnel to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to such personnel for such actions; providing that the absence of a POLST form does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation; amending s. 400.605, F.S.; requiring the Department of Elderly Affairs, in consultation with the agency, to adopt by rule procedures for the implementation of POLST forms in hospice care; amending s. 400.6095; F.S.; authorizing a hospice care team to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to a provider for such actions; providing that the absence of a POLST form does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation; amending s. 401.35, F.S.; requiring the Department of Health to establish circumstances and procedures for honoring a POLST form; amending s. 401.45, F.S.; authorizing emergency medical transportation providers to withhold or withdraw cardiopulmonary resuscitation or other

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medical interventions if a patient has a POLST form that contains such an order; amending s. 429.255, F.S.; authorizing assisted living facility personnel to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to facility staff and facilities for such actions; providing that the absence of a POLST form does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation; amending s. 429.73, F.S.; requiring the Department of Elderly Affairs to adopt rules for the implementation of POLST forms in adult family-care homes; authorizing a provider of such home to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to a provider for such actions; amending s. 456.072, F.S.; providing that a licensee may withhold or withdraw cardiopulmonary resuscitation or the use of an external defibrillator if presented with an order not to resuscitate or a POLST form that contains an order not to resuscitate; requiring the Department of Health to adopt rules providing for the implementation of such orders; providing immunity to licensees for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated defibrillator pursuant to such orders; amending s. 765.205, F.S.; requiring a health care surrogate to provide written

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consent for a POLST form under certain circumstances;
providing an effective date.

By Senator Brandes

22-00129C-16 2016664__

A bill to be entitled

An act relating to physician orders for life-sustaining treatment; creating s. 408.064, F.S.; defining terms; requiring the Department of Health to develop, and adopt by rule, a physician order for life-sustaining treatment (POLST) form; providing requirements for the POLST form; requiring the signature and attestation of a physician on a POLST form; providing requirements for a POLST form to be valid; prohibiting a POLST form from being required as a condition for treatment; requiring the review of a POLST form in certain circumstances; providing for the expiration of a POLST form; requiring the Agency for Health Care Administration to act as the state clearinghouse for compassionate and palliative care plans and information on those plans; requiring that such plans and information be electronically accessible to specified health care providers; requiring the agency to develop and maintain a database that allows the electronic submission of a compassionate and palliative care plan by a resident of this state which indicates his or her advance directives for care, the electronic storage and retrieval of such plans, and access to such plans by specified health care providers; requiring the agency to consult with advisers and experts as necessary and appropriate to facilitate the development and implementation of the database; authorizing the agency to subscribe to or participate in a public or private

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clearinghouse, which may be nationwide, in lieu of establishing and maintaining an independent database; requiring the agency to publish and disseminate certain information and provide certain training relating to the database; amending ss. 395.1041, 400.142, and 400.487, F.S.; authorizing specified personnel to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to such personnel for such actions; providing that the absence of a POLST form does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation; amending s. 400.605, F.S.; requiring the Department of Elderly Affairs, in consultation with the agency, to adopt by rule procedures for the implementation of POLST forms in hospice care; amending s. 400.6095, F.S.; authorizing a hospice care team to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to a provider for such actions; providing that the absence of a POLST form does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation; amending s. 401.35, F.S.; requiring the Department of Health to establish circumstances and procedures for honoring a POLST form; amending s. 401.45, F.S.; authorizing emergency medical transportation providers to withhold or withdraw

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

cardiopulmonary resuscitation or other medical interventions if a patient has a POLST form that contains such an order; amending s. 429.255, F.S.; authorizing assisted living facility personnel to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to facility staff and facilities for such actions; providing that the absence of a POLST form does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation; amending s. 429.73, F.S.; requiring the Department of Elderly Affairs to adopt rules for the implementation of POLST forms in adult family-care homes; authorizing a provider of such home to withhold or withdraw cardiopulmonary resuscitation if a patient has a POLST form that contains such an order; providing immunity from civil and criminal liability to a provider for such actions; amending s. 456.072, F.S.; providing that a licensee may withhold or withdraw cardiopulmonary resuscitation or the use of an external defibrillator if presented with an order not to resuscitate or a POLST form that contains an order not to resuscitate; requiring the Department of Health to adopt rules providing for the implementation of such orders; providing immunity to licensees for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated defibrillator pursuant to such orders; amending s. 765.205, F.S.;

requiring a health care surrogate to provide written consent for a POLST form under certain circumstances; providing an effective date.

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

Section 1. Section 408.064, Florida Statutes, is created to read:

408.064 Clearinghouse for compassionate and palliative care plans; POLST form.—

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

(a) "Advance directive" has the same meaning as in s. 765.101.

(b) "Compassionate and palliative care plan" or "plan" means an end-of-life document or any medical directive document recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, do-not-resuscitate order, physician order for life-sustaining treatment (POLST), or health care surrogate designation.

(c) "Department" means the Department of Health.

(d) "Do-not-resuscitate order" means an order issued pursuant to s. 401.45(3).

(e) "End-stage condition" has the same meaning as in s. 765.101.

(f) "Physician order for life-sustaining treatment" or "POLST" means a voluntary document, executed on a form adopted by department rule, which specifies a patient's desired end-of-life care and medical treatment to ensure that his or her wishes are honored. A POLST emphasizes advance care planning and shared

decision-making among a patient and his or her health care professionals and loved ones about the medical care the patient would like to receive upon the occurrence of specified conditions at or near the end of his or her life.

(2) POLST FORM.—The department shall develop and adopt by rule a POLST form. The form must be signed by the patient's physician after consultation with the patient or, if the patient is incapacitated, with the patient's legally authorized health care surrogate or proxy as provided in chapter 765 or with the patient's court-appointed guardian as provided in chapter 744.

(a) A POLST form is not valid unless the patient's physician attests in a signed, written statement that, in his or her good faith clinical judgment, at the time the POLST form is completed, the patient has the ability to make and communicate health care decisions or, in the event of the incapacity of the patient, that the patient's health care surrogate or other legal representative has such ability.

(b) A POLST form must prominently state in a conspicuous location on the document that completion of a POLST is voluntary, the use of a POLST form may not be required as a condition for treatment of any kind, and a POLST form may not be given effect if the patient is conscious and competent to make health care decisions. Such decisions will determine the patient's treatment, notwithstanding any directives included in the form.

(c) Decisions and instructions may not be preselected on a POLST form.

(d) A POLST form may be completed only by or for a patient determined by the patient's physician to have an end-stage

condition or a patient who, in the good faith clinical judgment of his or her physician, is suffering from at least one life-limiting medical condition that will likely result in the death of the patient within 1 year.

(e) A POLST form must include information on hydration in the context of the patient's actual condition at the time the POLST is executed.

(f) At a minimum, a POLST form must be reviewed by the patient's physician when the patient:

1. Is transferred from one health care setting or level of care to another;

2. Is discharged from a health care setting to return home;

3. Experiences a substantial change in his or her condition as determined by that physician; or

4. Changes his or her treatment preferences.

(g) A POLST form expires 1 year after the patient or the patient's health care surrogate or other legal representative signs the form or through the end of the course of treatment addressed by the POLST, whichever occurs first.

(3) INFORMATION CLEARINGHOUSE AND ESTABLISHMENT OF ELECTRONIC DATABASE.—The agency shall act as a clearinghouse of information on compassionate and palliative care plans, which must be accessible to health care providers. The agency shall develop and maintain as part of the clearinghouse a reliable and secure database that allows the electronic submission, storage, indexing, and retrieval of plans submitted by residents of this state, which plans may be accessed by a resident's treating health care provider. The agency shall consult with compassionate and palliative care providers, health care

facilities, and residents of this state as necessary and appropriate to facilitate the development and implementation of the database. The agency may subscribe to or otherwise participate in a public or private clearinghouse, which may be nationwide, to meet the requirements of this subsection. The agency shall publish and disseminate to residents of this state information regarding its role as a clearinghouse and the availability of the database. The agency shall also provide training to health care providers and health care facilities in this state as to how to access plans through the database.

Section 2. Paragraph (l) of subsection (3) of section 395.1041, Florida Statutes, is amended to read:

395.1041 Access to emergency services and care.—

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(l) Hospital personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate. Facility staff and facilities are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 408.064 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise allowed ~~permitted~~ by law.

Section 3. Subsection (3) of section 400.142, Florida Statutes, is amended to read:

400.142 Emergency medication kits; orders not to resuscitate.—

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate. Facility staff and facilities are not subject to criminal prosecution or civil liability, or considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 408.064 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise allowed ~~permitted~~ by law.

Section 4. 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; physician orders for life-sustaining treatment.—

(1) 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.

(2) If ~~When~~ required by ~~the provisions of~~ chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician, physician assistant, or advanced registered nurse practitioner, acting within his or her respective scope of practice, shall establish treatment orders for a patient who is to receive skilled care. The treatment orders must be signed by the physician, physician assistant, or advanced registered nurse practitioner before a claim for payment for the skilled services is submitted by the home health agency. If the claim is submitted to a managed care organization, the treatment orders must be signed within the time allowed under the provider agreement. The treatment orders shall be reviewed, as frequently as the patient's illness requires, by the physician, physician assistant, or advanced registered nurse practitioner in consultation with the home health agency.

(3) A home health agency shall arrange for supervisory visits by a registered nurse to the home of a patient receiving home health aide services in accordance with the patient's direction, approval, and agreement to pay the charge for the visits.

(4) Each patient has the right to be informed of and to participate in the planning of his or her care. Each patient must be provided, upon request, a copy of the plan of care

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

established and maintained for that patient by the home health agency.

(5) If ~~When~~ nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

(6) The skilled care services provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

(7) Home health agency personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate. The agency shall adopt rules providing for the implementation of such orders. Home health personnel and agencies are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form and rules adopted by the agency.

Section 5. Paragraph (e) of subsection (1) of section 400.605, Florida Statutes, is amended to read:

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400.605 Administration; forms; fees; rules; inspections; fines.—

(1) The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. The department, in consultation with the agency, shall by rule establish minimum standards and procedures for a hospice pursuant to this part. The rules must include:

(e) Procedures relating to the implementation of advance ~~advanced~~ directives; physician orders for life-sustaining treatment (POLST) forms executed pursuant to s. 408.064; and do-not-resuscitate orders.

Section 6. Subsection (8) of section 400.6095, Florida Statutes, is amended to read:

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(8) The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Hospice staff are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 408.064 does not preclude a physician from withholding or withdrawing

cardiopulmonary resuscitation as otherwise allowed ~~permitted~~ by law.

Section 7. Subsection (4) of section 401.35, Florida Statutes, is amended to read:

401.35 Rules.—The department shall adopt rules, including definitions of terms, necessary to carry out the purposes of this part.

(4) The rules must establish circumstances and procedures under which emergency medical technicians and paramedics may honor orders by the patient's physician not to resuscitate executed pursuant to s. 401.45 or under a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate and the documentation and reporting requirements for handling such requests.

Section 8. Paragraph (a) of subsection (3) of section 401.45, Florida Statutes, is amended to read:

401.45 Denial of emergency treatment; civil liability.—

(3)(a) Resuscitation or other forms of medical intervention may be withheld or withdrawn from a patient by an emergency medical technician, ~~or~~ paramedic, or other health care professional if he or she is presented with evidence of a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate or perform other medical intervention, as applicable, or an order not to resuscitate by the patient's physician ~~is presented to the emergency medical technician or paramedic~~. To be valid, an order not to resuscitate~~, to be valid,~~ must be on the form adopted by rule of the department.

The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

Section 9. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order or a POLST form and rules adopted by the department. The absence of an order to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 408.064 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise allowed ~~permitted~~ by law.

Section 10. Subsection (3) of section 429.73, Florida Statutes, is amended to read:

429.73 Rules and standards relating to adult family-care homes.—

(3) The department shall adopt rules providing for the implementation of orders not to resuscitate and physician orders for life-sustaining treatment (POLST) forms executed pursuant to s. 408.064. The provider may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 408.064 which contains an order not to resuscitate. The provider is ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and may not ~~nor~~ be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such orders ~~an order~~ and applicable rules.

Section 11. Present subsections (7) and (8) of section 456.072, Florida Statutes, are redesignated as subsections (8) and (9), respectively, and a new subsection (7) is added to that section, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) A licensee may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Licensees are not subject to criminal prosecution or civil liability, and may

not be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator or otherwise carrying out the orders in an order not to resuscitate or a POLST form pursuant to such an order or POLST form and rules adopted by the department. The absence of an order to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 408.064 does not preclude a licensee from withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator or otherwise carrying out medical orders allowed by law.

Section 12. Paragraph (c) of subsection (1) of section 765.205, Florida Statutes, is amended to read:

765.205 Responsibility of the surrogate.—

(1) The surrogate, in accordance with the principal's instructions, unless such authority has been expressly limited by the principal, shall:

(c) Provide written consent using an appropriate form whenever consent is required, including a physician's order not to resuscitate or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 408.064.

Section 13. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 21, 2016

I respectfully request that **Senate Bill #664**, relating to **Physician Orders for Life-sustaining Treatment**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 22

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

Bill Number (if applicable)

Topic POLST SB 664 / Brandes + Gaetz

Amendment Barcode (if applicable)

Name Diane Gowski, MD

Job Title MD / physician

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Street

Clearwater FL 33756
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Phone 727-480-7574

Email dianetg@aol.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Florida Catholic Medical Association guilds (CMA)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/2016
Meeting Date

664
Bill Number (if applicable)

Topic POLST

Amendment Barcode (if applicable)

Name Teresa Ward

Job Title Attorney

Address PO Box 1125
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Speaking: ☐ For ☒ Against ☐ Information

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

Representing FLORIDA RIGHT TO LIFE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

664
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Michael Sheedy

Job Title _____

Address 201 W. Park Ave.
Street

Tall. 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 FL Conference of Catholic Bishops

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

01 FEB 16
Meeting Date

664
Bill Number (if applicable)

Topic PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENTS (POLST)
Amendment Barcode (if applicable)

Name MICHAEL MCQUONE (MICK-CUE-ONE)

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Email mmcquone@flaccb.org

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FLORIDA CONFERENCE OF CATHOLIC BISHOPS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

664
Bill Number (if applicable)

Topic POLSTs

Amendment Barcode (if applicable)

Name Martha Edenfield

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Speaking: ☐ For ☐ Against ☐ Information

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

Representing The Real Property, Probate + Trust Law Section of the Florida Bar (working w/ sponsor)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

SB 664
Bill Number (if applicable)

Topic POLST

Amendment Barcode (if applicable)

Name Ken Brummel-Smith MD

Job Title Physician - State POLST Taskforce

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City *State* *Zip*

Email kenbrummelsmith@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing State POLST Task Force

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

↳ Sen Brandes ☒ yes

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 964
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Prescription Drug Monitoring Program
DATE:	February 1, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 964 exempts a rehabilitative hospital, assisted living facility, or nursing home that dispenses a dosage of a controlled substance to a patient from reporting that act of dispensing to the prescription drug monitoring program database (PDMP).

The bill also authorizes impaired practitioner consultants to access the PDMP information of impaired practitioner program participants who have agreed in writing to allow the consultants such access.

II. Present Situation:

The Prescription Drug Monitoring Program

Starting in the early 2000s, Florida began experiencing a marked increase in deaths resulting from prescription drug abuse. In 2010 the Florida Office of Drug Control identified prescription drug abuse as the most threatening substance abuse issue in Florida.[1] Between 2003 and 2009 the number of deaths caused by at least one prescription drug increased by 102 percent (from 1,234 to 2,488). These numbers translated into seven Floridians dying from prescription drug overdoses per day.

[1] Executive Office of the Governor, *Florida Office of Drug Control 2010 Annual Report* (on file with the Senate Committee on Health Policy).

Between 2009 and 2011, the Legislature enacted a series of reforms to combat prescription drug abuse. These reforms included strict regulation of pain management clinics; creating the Prescription Drug Monitoring Database (PDMP); and stricter regulation on selling, distributing, and dispensing controlled substances.[2]

Chapter 2009-197, Laws of Fla., established the PDMP in s. 893.055, F.S. The PDMP uses a comprehensive electronic system/database to monitor the prescribing and dispensing of certain controlled substances.[3] The PDMP became operational on September 1, 2011, when it began receiving prescription data from pharmacies and dispensing practitioners.[4] Dispensers have reported over 163 million controlled substance prescriptions to the PDMP since its inception.[5] Health care practitioners began accessing the PDMP on October 17, 2011.[6] Law enforcement agencies began requesting data from the PDMP in support of active criminal investigations on November 14, 2011.[7]

Dispensers of controlled substances listed in Schedule II, Schedule III, or Schedule IV must report specified information to the PDMP database within seven days after dispensing, each time the controlled substance is dispensed. The information required to be reported includes:[8]

- Name of the dispensing practitioner and Drug Enforcement Administration registration number, National Provider Identification, or other applicable identifier;
- Date the prescription is dispensed;
- Name, address, and date of birth of the person to whom the controlled substance is dispensed; and
- Name, national drug code, quantity, and strength of the controlled substance dispensed.[9]

Current law exempts certain acts of dispensing or administering from PDMP reporting:

- A health care practitioner when administering a controlled substance directly to a patient if the amount of the controlled substance is adequate to treat the patient during that particular treatment session.
- A pharmacist or health care practitioner when administering a controlled substance to a patient or resident receiving care as a patient at a hospital, nursing home, ambulatory surgical center, hospice, or intermediate care facility for the developmentally disabled which is licensed in this state.
- A practitioner when administering or dispensing a controlled substance in the health care system of the Department of Corrections.

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[2] See chs. 2009-197, 2010-211, and 2011-141, Laws of Fla.
[3] Section 893.055(2)(a), F.S.
[4] Florida Dep't of Health, *2012-2013 Prescription Drug Monitoring Program Annual Report* (December 1, 2013), *available at* http://www.floridahealth.gov/reports-and-data/e-forcse/news-reports/_documents/2012-2013pdmp-annual-report.pdf (last visited on Jan. 7, 2016).
[5] Florida Dep't of Health, *2014-2015 Prescription Drug Monitoring Program Annual Report* (December 1, 2015), *available at* http://www.floridahealth.gov/statistics-and-data/e-forcse/news-reports/_documents/2015-pdmp-annual-report.pdf (last visited on Jan. 7, 2016).
[6] *Supra* note 16
[7] *Supra* note 16
[8] The specific information reported depends upon the whether the reporter is a pharmacy or practitioner.
[9] *See* s. 893.055(3), F.S.

- A practitioner when administering a controlled substance in the emergency room of a licensed hospital.
- A health care practitioner when administering or dispensing a controlled substance to a person under the age of 16.
- A pharmacist or a dispensing practitioner when dispensing a one-time, 72-hour emergency resupply of a controlled substance to a patient.

Accessing the PDMP database

Section 893.0551, F.S., makes certain identifying information[10] of a patient or patient's agent, a health care practitioner, a dispenser, an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy that is contained in records held by the department under s. 893.055, F.S., confidential and exempt from the public records laws in s. 119.07(1), F.S., and in article I, section 24(a) of the State Constitution.[11]

Direct access to the PDMP database is presently limited to medical doctors, osteopathic physicians, dentists, podiatric physicians, advanced registered nurse practitioners, physician assistants, and pharmacists.[12] Currently, prescribers are not required to consult the PDMP database before prescribing a controlled substance for a patient however physicians and pharmacists queried the database more than 3.7 million times in 2012, over 9.3 million times in 2014, and over 18.6 million times in 2015.[13]

Indirect access to the PDMP database is provided to:
- The Department of Health (DOH) or certain health care regulatory boards;
- The Attorney General for Medicaid fraud cases;
- Law enforcement agencies during active investigations[14] involving potential criminal activity, fraud, or theft regarding prescribed controlled substances if the law enforcement agency has entered into a user agreement with the DOH; and
- Patients, or the legal guardians or designated health care surrogates of incapacitated patients.[15]

Indirect access means the person must request the information from the PDMP manager. After an extensive process to validate and authenticate the request and the requestor, the PDMP manager or support staff provides the specific information requested.[16]

[10] Such information includes name, address, telephone number, insurance plan number, government-issued identification number, provider number, and Drug Enforcement Administration number, or any other unique identifying information or number.
[11] Section 893.0551(2)(a)-(h), F.S.
[12] Section 893.055(7)(b), F.S.
[13] *Supra* at notes 16 and 17.
[14] Section 893.055(1)(h), F.S., defines an "active investigation" as an investigation that is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings, or that is ongoing and continuing and for which there is a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.
[15] Section 893.055(7)(c)1.-4., F.S.
[16] See s. 893.055(7)(c), F.S., and Rule 64k-1.003, F.A.C.

III. Effect of Proposed Changes:

CS/SB 964 amends s. 893.055, F.S., to exempt a rehabilitative hospital, assisted living facility, or nursing home that dispenses a certain dosage of a controlled substance, as needed, to a patient pursuant to an order of the patient's treating physician from reporting that act of dispensing to the prescription drug monitoring program database. These settings are low-risk with administration being monitored by facility staff.

The bill amends ss. 893.055 and 893.0551, F.S., to authorize impaired practitioner consultants to access the information in the PDMP relating to impaired practitioner program participants, or persons who are referred to the program, who have agreed voluntarily, in writing, to allow the consultant access to the information for initial evaluation and monitoring purposes. The impaired practitioner consultant is authorized indirect access only. Consequently, the program manager, or staff, must verify the authenticity of the request prior to release of the information.

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:

This bill does not create or expand a public records exemption and therefore does not require two-thirds vote for passage..

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Eliminating the reporting requirement will have a favorable impact on rehabilitative hospitals, assisted living facilities, and nursing homes due to increased efficiencies and reduced administrative costs.

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: 893.055 and 893.0551.

IX. Additional Information:

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

CS by Health Policy on February 1, 2016:
The CS authorizes a consultant in the impaired practitioner program indirect access to information in the PDMP concerning a participant or person referred to the PRN or IPN program.

B. Amendments:

None.

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

623746

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/01/2016	.	
	.	
	.	
	.	

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

Senate Amendment (with directory and title amendments)

Between lines 20 and 21

insert:

(7)

(c) The following entities are ~~shall~~ not ~~be~~ allowed direct access to information in the prescription drug monitoring program database but may request from the program manager and, when authorized by the program manager, the program manager's program and support staff, information that is confidential and exempt under s. 893.0551. Before ~~Prior to~~ release, a ~~the~~ request

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by the following entities shall be verified as authentic and authorized with the requesting organization by the program manager, the program manager's program and support staff, or as determined in rules by the department as being authentic and as having been authorized by the requesting entity:

1. The department or its relevant health care regulatory boards responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons who are authorized to prescribe, administer, or dispense controlled substances and who are involved in a specific controlled substance investigation involving a designated person for one or more prescribed controlled substances.

2. The Attorney General for Medicaid fraud cases involving prescribed controlled substances.

3. A law enforcement agency during active investigations of ~~regarding~~ potential criminal activity, fraud, or theft regarding prescribed controlled substances.

4. A patient or the legal guardian or designated health care surrogate of an incapacitated patient as described in s. 893.0551 who, for the purpose of verifying the accuracy of the database information, submits a written and notarized request that includes the patient's full name, address, and date of birth, and includes the same information if the legal guardian or health care surrogate submits the request. The request shall be validated by the department to verify the identity of the patient and the legal guardian or health care surrogate, if the patient's legal guardian or health care surrogate is the requestor. Such verification is also required for any request to change a patient's prescription history or other information

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related to his or her information in the electronic database.

5. An impaired practitioner consultant who is retained by the department under s. 456.076 for the purpose of reviewing the database information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and who has separately agreed in writing to the consultant's access to and review of such information.

Information in the database for the electronic prescription drug monitoring system is not discoverable or admissible in any civil or administrative action, except in an investigation and disciplinary proceeding by the department or the appropriate regulatory board.

Section 2. Paragraph (h) is added to subsection (3) of section 893.0551, Florida Statutes, and subsections (6) and (7) of that section are republished, to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(3) The department shall disclose such confidential and exempt information to the following persons or entities upon request and after using a verification process to ensure the legitimacy of the request as provided in s. 893.055:

(h) An impaired practitioner consultant who has been authorized in writing by a participant in, or by a referral to, the impaired practitioner program to access and review information as provided in s. 893.055(7)(c)5.

(6) An agency or person who obtains any confidential and exempt information pursuant to this section must maintain the

623746

confidential and exempt status of that information and may not disclose such information unless authorized by law. Information shared with a state attorney pursuant to paragraph (3)(a) or paragraph (3)(c) may be released only in response to a discovery demand if such information is directly related to the criminal case for which the information was requested. Unrelated information may be released only upon an order of a court of competent jurisdiction.

(7) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

And the directory clause is amended as follows:

Delete line 12

and insert:

section 893.055, Florida Statutes, and paragraph (c) of subsection (7) of that section is amended, to read:

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

And the title is amended as follows:

Delete line 6

and insert:

to the prescription drug monitoring program; authorizing an impaired practitioner consultant to access an impaired practitioner program participant's or referral's record in the prescription drug monitoring program's database; amending s. 893.0551, F.S.; requiring the Department of Health to disclose

623746

certain information from the prescription drug monitoring program to an impaired practitioner consultant under certain circumstances; providing

By Senator Grimsley

21-01381-16 2016964__

A bill to be entitled

An act relating to the prescription drug monitoring program; amending s. 893.055, F.S.; providing that certain acts of dispensing controlled substances in specified facilities are not required to be reported to the prescription drug monitoring program; providing an effective date.

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

Section 1. Paragraph (g) is added to subsection (5) of section 893.055, Florida Statutes, to read:

893.055 Prescription drug monitoring program.—

(5) When the following acts of dispensing or administering occur, the following are exempt from reporting under this section for that specific act of dispensing or administration:

(g) A rehabilitative hospital, assisted living facility, or nursing home dispensing a certain dosage of a controlled substance, as needed, to a patient as ordered by the patient's treating physician.

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

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 13, 2016

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

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/11
Meeting Date

964
Bill Number (if applicable)

623746
Amendment Barcode (if applicable)

Topic PDMP

Name Linda Smith

Job Title CEO

Address PO Box - 49130
Street
Jax Beach, FL 32240-9130
City *State* *Zip*

Phone 904-270-1620 x118

Email lsmith@ipnf.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Intervention Project for Nurses

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/2016
Meeting Date

964
Bill Number (if applicable)

623746
Amendment Barcode (if applicable)

Topic PDMP

Name Stefano Leitner

Job Title Medical Student Member of the PRN Board of Directors, appointed by FMA

Address PO Box 16510
Street

Phone 904-277-8004

Fernandina Beach FL 32035
City *State* *Zip*

Email drziegler@FLPRN.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Professionals Resource Network

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

964
Bill Number (if applicable)

Topic PDMP

623746
Amendment Barcode (if applicable)

Name Penelope P. Ziegler M.D.

Job Title Medical Director

Address P.O. Box 16510
Street

Phone 904-277-8004

Fernandina Beach FL 32035
City *State* *Zip*

Email drziegler@flpm.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing PRN

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

964
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic PDMP

Name Melody Arnold

Job Title Govt Affairs Mngr

Address 307 W. Park Ave
Street

TLH FL 32301
City *State* *Zip*

Phone (850) 224-3907

Email marnold@fhca.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL HealthCare Assoc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1082
INTRODUCER:	Senator Latvala
SUBJECT:	Evaluation of Students with Impairing Conditions Who are Preparing for Licensure as Health Care Practitioners or Veterinarians
DATE:	January 28, 2016 REVISED:

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

I. Summary:

SB 1082 creates a Hardship Evaluation Program for enrolled students who are preparing for licensure as health care practitioners or veterinarians and who are referred to an impaired practitioner program but cannot afford the required evaluation. The program will be funded, and the funding capped, by specific legislative appropriation or approved operating budgets in the Department of Health (DOH), Medical Quality Assurance (MQA) trust fund.

II. Present Situation:

Impaired Student Health Care and Student Veterinary Practitioner Treatment Programs

Section 456.076, F.S., provides resources to assist health care practitioners[1] who are impaired as a result of the misuse or abuse of alcohol, drugs, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety. For professions that do not have impaired practitioner programs provided for in their practice acts, the DOH designate**s** approved impaired practitioners and programs**.** There are currently two department-approved treatment programs for impaired practitioners in Florida, the Professionals Resource Network (PRN) and the Intervention Project for Nurses (IPN). These programs also serve as consultants to the DOH.[2]

[1] Health care practitioners are defined in s. 456.001(4), F.S., to include licensed acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, practitioners of electrolysis, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among other professions. These practitioners are regulated by the MQA within the DOH.

[2] *See* Professionals Resource Network, *available at* http://www.flprn.org/ and Intervention Project for Nurses, *available at* http://www.ipnfl.org/ (last visited Jan. 14, 2016).

Any information related to treatment of an impaired practitioner is exempt from state public records requirements except when a consultant determines that impairment affects a practitioner's practice, or ability to practice, and constitutes an immediate, serious danger to the public health, safety, or welfare.[3]

A medical school, or another school providing for the education of students enrolled in preparation for licensure as a health care practitioner, or a veterinarian, may contract with the DOH approved program or consultant to provide services to an enrolled student if the student is allegedly impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition.[4] The DOH is not responsible for paying for the care provided by approved treatment providers or a consultant.

The Department of Business and Professional Regulation (DBPR) regulates veterinarians and veterinary students and has no statutory authority under the general provisions in ch.455, F.S., to create its own impaired practitioner program for veterinarians or veterinary students. However, ch. 455, F.S., does provide for disciplinary action against persons who do not fully participate in the program operated by the DOH. Section 455.227(1)(u), F.S., states that, "termination from a treatment program for impaired practitioners as described in s.456.076, F.S., for failure to comply, without good cause, with the terms of the monitoring or treatment contract entered into by the licensee or failing to successfully complete a drug or alcohol treatment program," is grounds for disciplinary action from the DBPR. Further, s. 474.221, F. S., addresses impaired practitioner provisions for veterinarians licensed under ch. 474, and states that they shall be governed by the treatment of impaired practitioners under the provisions of s. 456.076, F.S., which includes veterinary students.

When a student is referred to PRN by his or her school, PRN reviews the intake information obtained from the school and makes a determination about the type of evaluation that is needed. The student is then given a choice of three possible PRN-approved evaluators and is responsible for contacting the chosen evaluator and setting up an appointment. The evaluation itself varies depending on the nature of the concern, but will always include an in-depth interview by the evaluator with the student, review of any relevant medical records, contact with the referral source and other significant collateral sources (treating practitioners, family members, significant other, etc.), and laboratory tests (which can include drug screens of urine, hair and blood; other lab studies as indicated). In many cases, formal psychological testing is also included. [5]

The cost of the evaluation is determined by the evaluator, and can vary from $300.00 to several thousand dollars depending on the nature of the evaluation, extent of testing required, etc. A straightforward evaluation for a student who has been arrested for driving under the influence with no history of other problems is generally in the $300.00-800.00 range. An evaluation for a student with an extensive history of mental health issues, substance use and behavioral disturbance including boundary violations, requiring a multidisciplinary team evaluation with complete neuropsychological evaluation, psychiatric evaluation, substance use evaluation, etc., can run $5,000.00 and up. The evaluation does not include treatment. The evaluator recommends

[3] Section 456.076(3)(e),(5) and (6), F.S.
[4] Section 456.076(1)(c)2., F. S.
[5] Penelope P. Ziegler, M.D., Medical Director, Professionals Resource Network, Inc., in correspondence to the Department of Health, November 2, 2015, (on file with the Senate Committee on Health Policy).

the type of treatment needed, if any; and PRN then provides options for treatment by PRN-approved treatment providers.[6]

The DOH contract with PRN and IPN specifies the duties and deliverables the PRN and IPN must provide. The Fiscal Year 2015-2016 annual contract amount for PRN is $1,919,907 and for IPN is $1,832,601. Currently, PRN has 970 enrollees; IPN has 1,394 enrollees. In 2013 and 2014, PRN evaluated 10 students each year.[7]

III. Effect of Proposed Changes:

SB 1082 creates s. 456.0765, F.S., to establish a Hardship Evaluation Program to fund mental or physical evaluations for enrolled students demonstrating financial hardship who are preparing for licensure as health care practitioners or veterinarians and who are referred to an impaired practitioner program. The purpose of the legislation is to protect public safety by assisting students who are, or may be, impaired as the result of the misuse or abuse of alcohol or drugs or due to a mental or physical condition that could affect the student's ability to practice with skill and safety when licensed.

Funds will be available each fiscal year as provided by legislative appropriation, or as an approved amendment to the DOH's operating budget. If funds are exhausted in any fiscal year, the program will cease operating until funding again becomes available, resulting in a halt of all student treatment in progress.

In order to qualify for assistance under the program a student must demonstrate, to the satisfaction of the consultant, the following:

- He or she is enrolled in an institution of higher learning in this state for the purpose of preparing for licensure as a health care practitioner or as a veterinarian;
- He or she has been referred to an impaired practitioner program because of an actual, or alleged, impairing condition that is the result of the misuse or abuse of alcohol or drugs or caused by a mental or physical condition that could affect the student's ability to practice with skill and safety when licensed;
- He or she is eligible for participation in the impaired practitioner program to which he or she has been referred;
- Additionally, the student will be required by the consultant to undergo a mental or physical evaluation, or both, and
- Must be unable to afford the cost of the evaluation due to financial hardship.

"Financial hardship" means the student:

- Is unemployed;
- Is receiving federal or state public assistance; or
- Has a monthly income that is at or below 150 percent of the federal income poverty level as published annually by the United States Department of Health and Human Services.

[6] *Id.*
[7] *Id.*

The federal poverty guidelines for 2015 establish that for a family of one, 150 percent of the federal income poverty guideline is $17,655 annually, or $1,471.25 monthly.[8]

The consultant operating the impaired practitioner program has the sole, non-reviewable, responsibility of determining if the student meets the eligibility requirements; and must obtain reasonable documentation of the financial hardship, but is not required to verify the authenticity or veracity of the documents. All records of the hardship program participants are to be redacted for any identifying information; and the DOH is to pay the evaluator's invoice. The bill does not require the submission of supporting documentation to substantiate the services were provided.

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:

Students who might not be able to afford an evaluation may be able to remain in school and become a productive licensed health care practitioner. This not only improves the personal resources of the individual, but may improve access to health care in the long run by expanding the health care workforce.

C. Government Sector Impact:

The DOH reports it will be required to obtain additional budget authority to implement the provisions of this bill; and will experience a recurring increase in costs in the contracted services category to pay invoices remitted by evaluators for evaluations.[9]

[8] 2015 Federal Poverty Guidelines, *available at* https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf, (last visited Jan. 28, 2016).
[9] Florida Dep't of Health, *Senate Bill 1082 Analysis*, p. 4 (on file with the Senate Committee on Health Policy).

Although unknown at this time, the contracted IPN and PRN services and programs may request additional fees to handle this additional workload.

The annual cost to DOH of the evaluations of veterinary students is also indeterminate at this time.

VI. Technical Deficiencies:

Section 456.076(2)(c)2., F.S., states, "The department is not responsible for paying for the care provided by approved treatment providers or a consultant." To avoid incongruous results, it might be advisable to provide an exception for evaluations performed pursuant to s. 457.0765, F.S., in this paragraph.

VII. Related Issues:

Oversight and fiscal accountability of the hardship program might need to be strengthened. Documentation demonstrating financial eligibility for the program is not required to be verified. The consultant's determination of eligibility is not subject to review under ch. 120, F.S. In addition, once the evaluation services (treatment) are completed the consultant forwards the invoice to DOH for payment. All records of the hardship participant are redacted and the department has no fiscal oversight or auditing responsibilities to ensure services were in fact provided as intended under the program.

VIII. Statutes Affected:

This bill creates section 456.0765 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

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

By Senator Latvala

20-01043-16 20161082__

A bill to be entitled

An act relating to the evaluation of students with impairing conditions who are preparing for licensure as health care practitioners or veterinarians; creating s. 456.0765, F.S.; creating the hardship evaluation program for students with financial hardships who are preparing for licensure as health care practitioners or veterinarians and who are referred to an impaired practitioners program; providing conditions for participation; providing for the submission of invoices to the Department of Health by consultants and for the payment of evaluators directly by the department; requiring the submission of monthly progress reports to the department; requiring that the identity of participating students be protected in billing for services and progress reports; providing for funding from the Medical Quality Assurance Trust Fund; providing an effective date.

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

Section 1. Section 456.0765, Florida Statutes, is created to read:

456.0765 Hardship evaluation program.—There is created the hardship evaluation program to fund the mental or physical evaluation of enrolled students who are preparing for licensure as health care practitioners or veterinarians and who are referred to an impaired practitioner program, but cannot afford the required evaluation. The purpose of the hardship evaluation program is to protect the public safety by assisting such students who are or may be impaired as the result of the misuse

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

20-01043-16 20161082__

or abuse of alcohol or drugs or due to a mental or physical condition that could affect the student's ability to practice with skill and safety when licensed. The hardship evaluation program is a collaboration between the department and consultants retained by the department pursuant to s. 456.076 to operate the impaired practitioner program.

(1) A student must satisfy all of the following conditions to be eligible for participation in the hardship evaluation program:

(a) Be enrolled in an institution of higher learning in this state for the purpose of preparing for licensure as a health care practitioner as defined in this chapter or as a veterinarian under chapter 474.

(b) Be referred to an impaired practitioner program operated by a consultant retained by the department pursuant to s. 456.076 or other law because of an actual or alleged impairing condition that is the result of the misuse or abuse of alcohol or drugs or caused by a mental or physical condition that could affect the student's ability to practice with skill and safety when licensed.

(c) Be eligible for participation in the impaired practitioner program to which they have been referred.

(d) Be required by the consultant to undergo a mental or physical evaluation, or both, by an evaluator approved by the department or the consultant to determine whether the individual has an impairing condition.

(e) Be unable to afford the cost of the evaluation due to financial hardship, as determined under subsection (2), by the consultant operating the applicable impaired practitioner

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

program. For purposes of this paragraph, an individual has a financial hardship if he or she is unemployed; is receiving payments under a federal or state public assistance program; or has a monthly income that is at or below 150 percent of the federal income poverty level as published annually by the United States Department of Health and Human Services.

(2) The consultant operating the applicable impaired practitioner program is solely responsible for determining whether a student meets the eligibility criteria specified in subsection (1). The consultant must obtain reasonable documentation of financial hardship but is not required to verify the authenticity of the documentation and information received. The consultant's eligibility determination is final and not subject to review pursuant to chapter 120.

(3) After student eligibility for the hardship evaluation program has been determined and the evaluation has been completed, the consultant operating the impaired practitioner program shall redact any individually identifiable student information and forward the evaluator's invoice to the department for payment. Upon receipt of the invoice, the department shall pay the approved evaluator directly.

(4) The consultant must provide monthly progress reports to the department which include the number of hardship evaluation program participants and, for each participant, the cost of his or her examination, a summary of his or her status in the program, the name of his or her evaluator, the date of his or her evaluation, and the date that he or she is expected to complete his or her participation in the impaired practitioner program. Progress reports may not contain any individually

identifiable student information.

(5) Funding for the hardship evaluation program shall be made available each fiscal year from the Medical Quality Assurance Trust Fund as provided by legislative appropriation or an approved amendment to the department's operating budget pursuant to chapter 216. If available funding is exhausted in any fiscal year, the program shall cease operation until funding becomes available.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Transportation, Tourism, and Economic Development, *Chair*
Appropriations
Commerce and Tourism
Governmental Oversight and Accountability
Regulated Industries
Rules

SENATOR JACK LATVALA
20th District

January 13, 2016

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

Dear Chairman Bean:

I respectfully request consideration of Senate Bill 1082/ Evaluation of Students with Impairing Conditions Who are Preparing for Licensure as Health Care Practitioners or Veterinarians by the Senate Committee on Health Policy at your earliest convenience.

This bill creates the hardship evaluation program for students with financial hardships who are preparing for licensure as health care practitioners or veterinarians and who are referred to an impaired practitioners program.

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

Sincerely,

Jack Latvala
State Senator
District 20

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

REPLY TO:
☐ 26133 U.S. Highway 19 North, Suite 201, Clearwater, Florida 33763 (727) 793-2797 FAX: (727) 793-2799
☐ 408 Senate Office Building, 404 South Monroe Street. Tallahassee, Florida 32399-1100 (850) 487-5020

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Transportation, Tourism, and Economic Development, *Chair*
Appropriations
Commerce and Tourism
Governmental Oversight and Accountability
Regulated Industries
Rules

SENATOR JACK LATVALA
20th District

February 1, 2016

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

Dear Chair Bean:

My bill on Evaluation of Students with Impairing Conditions Who are Preparing for Licensure as Health Care Practitioners or Veterinarians, Senate Bill 1082, is scheduled to be heard in the Health Policy Committee on Monday, February 1st at 1:30 p.m. at the same time as my Governmental Oversight and Accountability Committee. I respectfully request that my legislative aide, Lizbeth Mabry, be permitted to present the bill before the Health Policy Committee.

Thank you for your consideration.

Sincerely,

Jack Latvala
Senator, District 20

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

REPLY TO:
☐ 26133 U.S. Highway 19 North, Suite 201, Clearwater, Florida 33763 (727) 793-2797 FAX: (727) 793-2799
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ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/2016
Meeting Date

SB-1082
Bill Number (if applicable)

Topic Hardship Program Evalution

Amendment Barcode (if applicable)

Name Robert Watson

Job Title Professor FSU COM

Address 1115 West Call St.
Street

Tallahassee Fl
City *State* *Zip*

Phone

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1082
Bill Number (if applicable)

Topic Evaluation of Students w/ Impairing Conditions

Amendment Barcode (if applicable)

Name Alisa LaPolt (ah LEE sa)

Job Title Lobbyist

Address PO Box 1344 *Street*

Phone 850-443-1319

Tallahassee FL 32302
City *State* *Zip*

Email alisa@gotopsail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Nurses Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1082
Bill Number (if applicable)

Topic Evaluations of Students w/ Impaired conditions

Amendment Barcode (if applicable)

Name Linda Smith

Job Title CEO

Address PO Box 49130 (*Street*)

Jax Bch, FL 32240 9130 (*City* / *State* / *Zip*)

Phone 904-270-1620 x118

Email lsmith@ipnfl.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Intervention Project for Nurses

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/2016
Meeting Date

1082
Bill Number (if applicable)

Topic Evaluation of Students

Amendment Barcode (if applicable)

Name Stefano Leitner

Job Title Medical Student Member of the PRN board of directors, appointed by FMA

Address P.O. Box 16510
Street

Phone 904-277-8004

Fernandina Beach | FL | 32035
City | *State* | *Zip*

Email drziegler@FLPRN.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Professionals Resource Network

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1082
Bill Number (if applicable)

Topic Student Hardship Evaluations

Amendment Barcode (if applicable)

Name Penelope P. Ziegler, M.D.

Job Title Medical Director

Address P.O. Box 16510
Street

Phone 904-277-8004

Fernandina Beach FL 32034
City *State* *Zip*

Email drziegler@flprn.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Professionals Resource Network (PRN)

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 1084
INTRODUCER:	Banking and Insurance Committee and Senator Gaetz
SUBJECT:	Health Care Protocols
DATE:	January 25, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1084 creates the "Right Medicine, Right Time Act." Timely access to health care can be a significant issue for anyone with an illness, but it is particularly critical for individuals who have conditions with the potential to cause death, disability, or serious discomfort unless treated with the most appropriate medical care. Generally, step-therapy or fail-first protocols for prescription drugs coverage require an insured or enrollee to try a certain drug, usually a generic alternative, before receiving coverage for another drug, usually a branded, and more expensive product.

The bill requires Medicaid managed care plans, health maintenance organizations (HMOs), and insurers that restrict medications by a step-therapy or fail-first protocol to have a clear and convenient process to request an override of the protocol. The bill requires these entities to grant an override of the protocol within 24 hours if, based on sound clinical evidence or medical and scientific evidence, the prescribing provider:

- Concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of the enrollee's disease or medical condition; or
- Believes that the preferred treatment required under the fail-first protocol is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the enrollee and the known characteristics of the drug regimen or will cause or is likely to cause an adverse reaction or other physical harm to the enrollee.

The bill requires that the duration of treatment may not exceed a period deemed appropriate by the prescribing provider, if the provider follows the fail-first protocol recommended by the

managed care plan for an enrollee. Following such period, if the prescriber deems the treatment provided under the protocol clinically ineffective, the enrollee is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol.

The bill prohibits an HMO from requiring a health care provider to use a clinical decision support system or a laboratory benefits management program before the provider may order clinical laboratory services or in an attempt to direct or limit the provider's medical decision-making relating to the use of such services. Advocates of clinical decision support systems and laboratory benefits management programs contend that these programs were developed to improve affordability and quality of care for enrollees and avoid errors and adverse events. Some opponents of these programs contend that these applications impinge upon medical judgment of the health care provider, cause delays in providing care, and increase costs.

II. Present Situation:

Regulation of Insurers and Health Maintenance Organizations in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[1] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[2] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[3]

Florida's Statewide Medicaid Managed Care

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. In Florida, the AHCA administers the program. Over 3.7 million Floridians are current enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over 23.4 billion.[4]

In 2013 and 2014, the agency implemented the legislatively mandated Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components: the Managed Medicaid Assistance (MMA) program and the Long-term Care program. The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014. Most Florida Medicaid recipients who are eligible for the full array of Florida Medicaid benefits are enrolled in an MMA plan.

[1] Section 20.121(3)(a), F.S.
[2] Section 641.21(1), F.S.
[3] Section 641.495, F.S.
[4] Office of Economic and Demographic Research, *Social Services Estimating Conference of August 4, 2015*, http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Jan. 26, 2016).

Managed care plans have the ability to implement service authorization and utilization management requirements for the services they provide under the SMMC program. However, Medicaid managed care plans are required to ensure that: service authorization decisions are based on objective evidenced-based criteria, utilization management procedures are applied consistently, and all decisions to deny or limit a requested service are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition/disease. The managed care plans are also required to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; consider the needs of the enrollees; are adopted in consultation with providers; and are reviewed and updated periodically, as appropriate. These guidelines are consistent with requirements found in federal regulations.[5]

The AHCA maintains coverage and limitations policies for most Florida Medicaid services. Medicaid managed care plans cannot be more restrictive than these policies or the Florida Medicaid State Plan (which is approved by the federal Centers for Medicare and Medicaid Services or CMS) in providing services to their enrollees. Managed care plans must notify enrollees and providers of the services they provide and inform them of any prior authorization requirements or coverage limitations in their respective handbooks.

Section 409.91195, F.S., establishes the Pharmaceutical and Therapeutics (P&T) committee within the AHCA for the development of a Florida Medicaid preferred drug list (PDL). The P&T committee meets quarterly, reviews all drug classes included in the formulary at least every 12 months, and may recommend additions to and deletions from the AHCA's Florida Medicaid PDL, such that the PDL provides for medically appropriate drug therapies for Florida Medicaid recipients and an array of choices for prescribers within each therapeutic class.

The AHCA also manages the federally required Medicaid Drug Utilization Board, which meets quarterly, develops, and reviews clinical prior authorization criteria, including step-therapy protocols for drugs that are not on the AHCA's Florida Medicaid PDL.

Managed care plans serving MMA enrollees are required to provide all prescription drugs listed on the AHCA's Florida Medicaid PDL for at least the first year of operation.[6] As such, the managed care plans have not implemented their own plan-specific formulary or PDL. The managed care plan's prior authorization criteria/protocols related to prescribed drugs cannot be more restrictive than the criteria established by the AHCA. The AHCA posts prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the AHCA's Internet Web site within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the AHCA, in accordance with s. 409.912, F.S. MMA plans may adopt the Florida Medicaid prior authorization criteria or

[5] 42 CFR s. 438.236(b).

[6] See Agency for Health Care Administration, *SMMC Plans, Model Contract, Attachment II, Core Contract Provisions,* p. 34 (effective November 1, 2015) *available at* http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml and the *Pharmacy Snapshot* (August 27, 2014) *available at* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Pharmacy_Snapshot_2014-08-27.pdf (last visited Jan. 26, 2016).

develop their own criteria. Prior authorization and step-therapy protocols for PDL may not be more restrictive than protocols posted on the AHCA's website.[7]

Section 409.967, F.S., currently requires managed care plans to publish any prescribed drug formulary or PDL on the plan's Web site in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its Web site and providing timely responses to providers.

Florida' State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group insurance program by providing employee benefits such as health, life, dental, and vision insurance products under a cafeteria plan consistent with section 125, Internal Revenue Code. To administer the state group health insurance program, the DMS contracts with third party administrators, HMOs, and a pharmacy benefits manager (PBM) for the state employees' prescription drug program pursuant to s. 110.12315, F.S.

The health plan administrators, HMOs and PBM each have their respective clinical coverage guidelines and utilization management practices to ensure appropriateness of care and to manage plan costs. These coverage guidelines are based on clinical evidence and recommendations from clinical and pharmacy and therapeutics committees comprised of practicing physicians and pharmacists. The National Committee for Quality Assurance and other national accreditation organizations define the structure and function of these committees, which have the same duties described for the proposed commission.

The state employees' self-insured prescription drug program has three cost-share categories for members: generic drugs, preferred brand name drugs (those brand name drugs on the preferred drug list), and non-preferred brand name drugs (those brand name drugs not on the preferred drug list). Contractually the PBM for the state employees' self-insured prescription drug program updates the preferred drug list quarterly as brand drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.[8]

Federal Patient Protection and Affordable Care Act

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[9] The PPACA provides fundamental changes to the U.S. health care system by

[7] Agency for Health Care Administration, *Senate Bill 1084 Analysis* (Jan.13, 2016) (on file with the Senate Committee on Banking and Insurance).
[8] Footnote 1A of s.110.12315, F.S., prohibits the state's prescription drug program from implementing a prior authorization program or step-therapy program for non-HMO members. Step-therapy is currently not in place for any state-group health plan member.
[9] The Patient Protection and Affordable Care Act (Pub. Law 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. Pub. Law 111-148.

requiring health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required essential health benefits, rating and underwriting standards, review of rate increases, and internal and external appeals of adverse benefit determinations.[10]

Qualifying coverage may be obtained through an employer, the federal or state marketplaces or exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard off the exchange. Florida did not establish its own state exchange under PPACA. Premium credits and other cost sharing subsidies are available to U.S. citizens and legal immigrants within certain income limits for qualified coverage purchased through the exchange. Premium credits are set on a sliding scale based on a percentage of the federal poverty level and reduce the out-of-pocket costs incurred by individuals and families.

Prior to an insurer offering a plan through an exchange, an exchange must certify that the plan meets certain federal essential health benefits and other requirements to be deemed a qualified health plan (QHP). Section 1302 of the Affordable Care Act requires QHPs to provide coverage of essential health benefits (EHB), meet cost-sharing limits and actuarial value requirements. The law directs that EHBs cover at least 10 specified categories, which includes prescription drugs.[11]

Final HHS Notice of Benefit and Payment Parameters for 2016

On March 20, 2014, the final HHS regulations relating to notice of benefit and payment parameters was released, which establishes key standards for issuers and marketplaces for 2016. These regulations include provisions relating to prescription drug coverage, formulary drug lists, and the drug exception process.[12]

Prescription Drug Coverage. Currently, for purposes of complying with the essential health benefits, insurers and HMOs must include in their formulary drug list the greater of one drug for each U.S. Pharmacopeia (USP) category and class; or the same number of drugs in each USP category and class as the state's essential health benefit (EHB) benchmark plan. For plan years beginning on or after January 1, 2017, plans must also use a P&T committee process that meets certain requirements. The P&T committee must design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines.[13]

Formulary Drug List. The regulations require a health plan must publish an up-to-date and complete list of all covered drugs on its formulary drug list, including any tiered structure and any restrictions on the manner in which a drug can be obtained, in a manner that is easily

[10] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. s. 300gg *et seq*.).
[11] See Centers for Medicare and Medicaid Services, *Florida's Benchmark Plan* https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited Jan.26, 2016).
[12] HHS, *Final HHS Notice of Benefit and Payment Parameters for 2016*, Factsheet, *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf (last visited Jan. 26, 2016).
[13] 45 C.F.R. s. 156.122.

accessible to plan enrollees, prospective enrollees, the state, the marketplace, HHS, and the public. Additionally, insurers and HMOs must also make this information available in a standard-readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.

Drug Exceptions Process. Under current HHS regulations, plans providing EHBs must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not included on the plan's formulary drug list. Such procedures must include a process to request an expedited review based on exigent circumstances. Under this expedited process, the issuer must make its coverage determination no later than 24 hours after it receives the request. This requirement, commonly referred to as the "exceptions process," applies to drugs that are not included on the plan's formulary drug list. For plan years beginning in 2016, these processes must also include certain processes and timeframes for the standard review process, and have an external review process if the internal review request is denied. The costs of the non-formulary drug provided through the exceptions process count towards the annual limitation on cost sharing and actuarial value of the plan.[14]

Cost Containment Measures Used by Insurers and HMOs

Prior Authorization and Step Therapy or Fail First Therapy

Insurers use many cost containment and utilization review strategies to manage medical and drug spending and patient safety. For example, plans may place utilization management requirements on the use of certain drugs on their formulary. This may include requiring enrollees to obtain prior authorization from their plan before being able to fill a prescription, requiring enrollees to try first a preferred drug to treat a medical condition before being able to obtain an alternate drug for that condition, or limiting the quantity of drugs that they cover over a certain period.

Under prior authorization, a health care provider is required to seek approval from an insurer before a patient may receive a specified diagnostic or therapeutic treatment or specified prescription drugs under the plan. A PDL is an established list of one or more prescription drugs within a therapeutic class deemed clinically equivalent and cost effective. In order to obtain another drug within the therapeutic class, not part of the PDL, prior authorization is required. Prior authorization for emergency services is not required. Preauthorization for hospital inpatient services is generally required.

In some cases, plans require an insured to try one drug first to treat his or her medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, a plan may require doctors to prescribe Drug A first. If Drug A does not work for a beneficiary, then the plan will cover Drug B. Advocates of step therapy state that a step therapy approach requires the use of a clinically recognized first-line drug before approval of a more complex and often more expensive medication where the safety, effectiveness, and values has been well established before a second-line drug is authorized.

[14] 45 C.F.R. s. 156.122(c). The drug exception process is distinct from the coverage appeals process, which applies if an enrollee receives an adverse benefit determination for a drug that is included on the plan's formulary drug list. The coverage appeals process has separate requirements for its external review process and allows for a secondary level of internal review before the final internal review determination for group plans. [45 C.F.R. s. 147.136]

According to a published report by researchers affiliated with the National Institutes of Health, there is mixed evidence on the impact of step therapy policies.[15] A review of the literature by Brenda Motheral found that there is little good empirical evidence,[16] but other studies[17] suggest that step therapy policies have been effective at reducing drug costs without increasing the use of other medical services. However, some studies have found that the policies can increase total utilization costs over the long run because of increased inpatient admissions and emergency department visits.[18] One-step therapy policy for a typical antipsychotic medication in a Medicaid program was associated with a higher rate of discontinuity in medication use, an outcome that was linked to increased risk for hospitalization.[19]

Clinical Decision Support Systems and Laboratory Benefit Management Programs

Clinical decision support (CDS) systems are designed to improve clinical decision-making and to provide a platform for integrating evidence based knowledge into health care delivery.[20] The CDS systems encompass a variety of tools to enhance decision-making in the clinical workflow. These tools include computerized alerts and reminders to care providers and patients; clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support, and contextually relevant reference information, among other tools.

Laboratory Benefit Management Programs. The Laboratory Benefit Management Program (program)[21] was developed to help manage appropriate utilization for outpatient laboratory services.[22] A pilot program, instituted in 2014, is limited to fully insured commercial members in Florida, excluding Neighborhood Health Partnership members. As part of the program, all outpatient laboratory services for these members are subject to new requirements including advance notification and new medical policies. If a provider orders laboratory services and their practice is located in Florida, the provider must use BeaconLBS Physician Decision Support when ordering any of the Decision Support Tests for members who are part of the program. The Physicians Decision Support system is an online tool that helps physicians select tests and laboratories using evidence-based guidelines and following insurer's policies. These tests are listed in the administrative protocol.

Associations that represent health care providers have expressed concerns about the negative impact that this electronic decision support program will have on the quality of and access to

[15] The Ethics Of "Fail First": Guidelines and Practical Scenarios for Step Therapy Coverage Policies, Rahul K. Nayak and Steven D. Pearson *Health Affairs* 33, No.10 (2014):1779-1785.
[16] Pharmaceutical Step Therapy Interventions: A Critical Review of the Literature, Brenda R. Motheral, *Journal of Managed Care Pharmacy* 17, no. 2 (2011) 143-55.
[17] *Supra* note 15, at 1780.
[18] *Id*.
[19] Id.
[20] See Health IT.Gov, *What is Clinical Decision Support* (updated January 15, 2013) *available at* https://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds (last visited Jan. 26, 2016).
[21] Beacon Laboratory Benefit Solutions, Inc. (BeaconLBS®), a subsidiary of LabCorp®, administers the Laboratory Benefit Management Program for UnitedHealthcare.
[22] UnitedHealthcare, *UnitedHealthcare Laboratory Benefit Management Program Frequently Asked Questions* (June 29, 2015) (on file with the Senate Committee on Banking and Insurance).

care for patients.[23] In particular, some have stated that the program interferes with the physician relationship and does not improve health care quality or access to care. These interactions, they argue, redirect valuable time and resources away from patients and add to a growing administrative burden that threatens the practice of medicine.[24]

III. Effect of Proposed Changes:

Section 1 states that the act may be known as the "Right Medicine Right Time Act."

Sections 2, 3, and 5 amends s. 409.967, F.S., and creates ss. 627.42392 and 641.394, F.S., respectively, relating to Medicaid managed care plans, insurers, and HMOs, that utilize a fail-first protocol. The bill requires Medicaid managed care plans, HMOs, and insurers that restrict medications by a step-therapy or fail-first protocol to have a clear and convenient process to request an override of the protocol. The bill requires these entities to grant an override of the protocol within 24 hours if, based on sound clinical evidence or medical and scientific evidence, the prescribing provider:

- Concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of the enrollee's disease or medical condition; or
- Believes that the preferred treatment required under the fail-first protocol is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the enrollee and the known characteristics of the drug regimen, or will cause or is likely to cause an adverse reaction or other physical harm to the enrollee.

The bill requires that the duration of treatment may not exceed a period deemed appropriate by the prescribing provider, if the provider follows the fail-first protocol recommended by the managed care plan for an enrollee. Following such period, if the prescriber deems the treatment provided under the protocol clinically ineffective, the enrollee is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol.

Section 4 of the bill amends s. 641.31, F.S., to prohibit an HMO from requiring a health care provider to use a clinical decision support system or a laboratory benefits management program before the provider may order clinical laboratory services or in an attempt to direct or limit the provider's medical decision-making relating to the use of such services. The term, "clinical decision support system," means software designed to direct or assist clinical decision-making by matching the characteristics of an individual patient to a computerized clinical knowledge base and providing patient-specific assessments or recommendations based on the match. The term, "laboratory benefits management program," means an HMO protocol that dictates or limits health care provider decision-making relating to the use of clinical laboratory services. Further, the term, "clinical laboratory services" is defined. The bill specifies that this provision does not prohibit prior authorization requirements that the HMO has regarding the provision of clinical laboratory services.

[23] James L. Madara, M.D., correspondence with UnitedHealth Group (Mar. 18, 2015) (on file with Senate Committee on Banking and Insurance).
[24] Allen Pillersdorf, M.D., correspondence with UnitedHealthcare (on file with Senate Committee on Banking and Insurance).

Section 6 provides that this act 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.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Implementation of the bill may provide health care providers with a greater number of prescription drugs to meet the unique medical needs of their patients and reduce the administrative burden associated with current step therapy or fail first therapy protocols.

To the extent that current step therapy policies contribute to increased costs from increased inpatient admissions and hospital emergency visits, the bill may serve to reduce those costs.

Medicaid managed care plans, insurers, and HMOs may experience an indeterminate increase in costs associated with changes in the step therapy protocols provided in the bill. These cost increases are likely to pass through to the purchasers of health insurance, such as individuals and employers.

The provisions of the bill would not apply to self-insured health plans since plans are preempted from state regulation under the Employee Retirement Income Security Act of 1974. In Florida, an estimated 60 percent of private-sector enrollees obtain coverage through a self-insured plan.

C. Government Sector Impact:

Medicaid

The Agency for Health Care Administration indicates that the fiscal impact to Florida Medicaid under the provisions and language of the bill is indeterminate. If the bill is enacted, it may have an operational and fiscal impact on the Florida Medicaid program,

as it establishes an enrollee entitlement to a prescription after one use of the fail-first protocol and exempts the provider from seeking an override of the fail-first protocol. It is unclear how the bill applies if the health plans themselves do not have restrictions. This will not allow managed care plans to apply the medical necessity definition or utilization management criteria for any prescribed treatment subsequent to the first prescription utilized under the fail-first protocol.[25]

Division of State Group Insurance/DMS

According to the DMS, with regard to the fail-first protocol (step-therapy) override process requirement for insurers and HMOs, the bill does not affect the state group insurance prescription drug program, as step-therapy is not currently a provision of the plan design.

Further, the DMS states that the provision in the bill that prohibits HMOs from requiring health care providers to use a clinical decision support system or a laboratory benefits management program, to direct or limit provider's decision-making ability could affect the state group health insurance program. Changes to current medical management procedures that cause an HMO's medical costs to increase would result in higher negotiated premiums for the state-contracted HMOs.[26]

Office of Insurance Regulation

Indeterminate. The OIR did not provide a fiscal impact of implementing the provisions of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967 and 641.31.

This bill creates the following sections of the Florida Statutes: 627.42392 and 641.394.

[25] Agency for Health Care Administration, *Senate Bill 1084 Fiscal Analysis* (Jan. 13, 2016) (on file with the Senate Committee on Banking and Insurance).
[26] Department of Management Services, *Senate Bill 1084 Fiscal Analysis* (Jan. 14, 2016) (on file with the Senate Committee on Banking and Insurance).

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 Banking and Insurance on January 19, 2016:
The effective date of the bill was changed from July 1, 2016, to January 1, 2017. Further, the bill was revised to apply the provisions relating to step therapy or fail first protocols to individual and group insurance policies and HMO contracts.

B. Amendments:

None.

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

By the Committee on Banking and Insurance; and Senator Gaetz

597-02307-16 20161084c1

A bill to be entitled

An act relating to health care protocols; providing a short title; amending s. 409.967, F.S.; requiring a managed care plan to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term "fail-first protocol"; creating s. 627.42392, F.S.; requiring an insurer to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term "fail-first protocol"; amending s. 641.31, F.S.; prohibiting a health maintenance organization from requiring that a health care provider use a clinical decision support system or a laboratory benefits management program in certain circumstances; defining terms; providing for construction; creating s. 641.394, F.S.; requiring a health maintenance organization to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term "fail-first protocol"; providing an effective date.

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

Section 1. This act may be known as the "Right Medicine Right Time Act."

Section 2. Paragraph (c) of subsection (2) of section

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

597-02307-16 20161084c1

409.967, Florida Statutes, is amended 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:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the

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

availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2.a. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

b. If a managed care plan restricts the use of prescribed drugs through a fail-first protocol, it must establish a clear and convenient process that a prescribing physician may use to request an override of the restriction from the managed care plan. The managed care plan shall grant an override of the protocol within 24 hours if:

(I) Based on sound clinical evidence, the prescribing provider concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of the enrollee's disease or medical condition; or

(II) Based on sound clinical evidence or medical and scientific evidence, the prescribing provider believes that the

preferred treatment required under the fail-first protocol:

(A) Is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the enrollee and the known characteristics of the drug regimen; or

(B) Will cause or is likely to cause an adverse reaction or other physical harm to the enrollee.

If the prescribing provider follows the fail-first protocol recommended by the managed care plan for an enrollee, the duration of treatment under the fail-first protocol may not exceed a period deemed appropriate by the prescribing provider. Following such period, if the prescribing provider deems the treatment provided under the protocol clinically ineffective, the enrollee is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol. As used in this subparagraph, the term "fail-first protocol" means a prescription practice that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families shall ~~must~~ maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted

community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department are ~~shall be~~ the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 3. Section 627.42392, Florida Statutes, is created to read:

627.42392 Fail-first protocols.—If an insurer restricts the use of prescribed drugs through a fail-first protocol, it must establish a clear and convenient process that a prescribing physician may use to request an override of the restriction from the insurer. The insurer shall grant an override of the protocol within 24 hours if:

(1) Based on sound clinical evidence, the prescribing provider concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(2) Based on sound clinical evidence or medical and scientific evidence, the prescribing provider believes that the preferred treatment required under the fail-first protocol:

(a) Is likely to be ineffective given the known relevant

physical or mental characteristics and medical history of the insured and the known characteristics of the drug regimen; or

(b) Will cause or is likely to cause an adverse reaction or other physical harm to the insured.

If the prescribing provider follows the fail-first protocol recommended by the insurer for an insured, the duration of treatment under the fail-first protocol may not exceed a period deemed appropriate by the prescribing provider. Following such period, if the prescribing provider deems the treatment provided under the protocol clinically ineffective, the insured is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol. As used in this section, the term "fail-first protocol" means a prescription practice that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

Section 4. Subsection (44) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(44) A health maintenance organization may not require a health care provider, by contract with another health care provider, a patient, or another individual or entity, to use a clinical decision support system or a laboratory benefits management program before the provider may order clinical laboratory services or in an attempt to direct or limit the provider's medical decisionmaking relating to the use of such

services. This subsection may not be construed to prohibit any prior authorization requirements that the health maintenance organization may have regarding the provision of clinical laboratory services. As used in this subsection, the term:

(a) "Clinical decision support system" means software designed to direct or assist clinical decisionmaking by matching the characteristics of an individual patient to a computerized clinical knowledge base and providing patient-specific assessments or recommendations based on the match.

(b) "Clinical laboratory services" means the examination of fluids or other materials taken from the human body, which examination is ordered by a health care provider for use in the diagnosis, prevention, or treatment of a disease or in the identification or assessment of a medical or physical condition.

(c) "Laboratory benefits management program" means a health maintenance organization protocol that dictates or limits health care provider decisionmaking relating to the use of clinical laboratory services.

Section 5. Section 641.394, Florida Statutes, is created to read:

641.394 Fail-first protocols.—If a health maintenance organization restricts the use of prescribed drugs through a fail-first protocol, it must establish a clear and convenient process that a prescribing physician may use to request an override of the restriction from the health maintenance organization. The health maintenance organization shall grant an override of the protocol within 24 hours if:

(1) Based on sound clinical evidence, the prescribing provider concludes that the preferred treatment required under

the fail-first protocol has been ineffective in the treatment of the subscriber's disease or medical condition; or

(2) Based on sound clinical evidence or medical and scientific evidence, the prescribing provider believes that the preferred treatment required under the fail-first protocol:

(a) Is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the subscriber and the known characteristics of the drug regimen; or

(b) Will cause or is likely to cause an adverse reaction or other physical harm to the subscriber.

If the prescribing provider follows the fail-first protocol recommended by the health maintenance organization for a subscriber, the duration of treatment under the fail-first protocol may not exceed a period deemed appropriate by the prescribing provider. Following such period, if the prescribing provider deems the treatment provided under the protocol clinically ineffective, the subscriber is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol. As used in this section, the term "fail-first protocol" means a prescription practice that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

Section 6. This act shall take effect January 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1084
Bill Number (if applicable)

Topic HEALTH CARE PROTOCOLS

Amendment Barcode (if applicable)

Name JACK McRAY

Job Title

Address 200 W. COLLEGE ST. , # 304
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TLH FL 32301
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Email jmcray@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

1084
Bill Number (if applicable)

Topic Health Care Protocols

Amendment Barcode (if applicable)

Name MIKE FISCHER

Job Title

Address PO BOX 1197
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Phone 222-6344

Email mike@redfishconsult.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AMERICAN CANCER SOCIETY

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1054
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nland

Job Title _____

Address 1000 Riverside Ave
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Jacksonville, FL 32204
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Phone 904-233-3051

Email nlandlawe aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Gastroenterologic Society

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

2-1-2016
412-K
1:30

THE FLORIDA SENATE

APPEARANCE RECORD

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2-1-2016
Meeting Date

SB 1084
Bill Number (if applicable)

Topic HEALTH CARE PROTOCOLS

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

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TALLAHASSEE FL 32301
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Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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2/1
Meeting Date

1084
Bill Number (if applicable)

Topic Health Care Protocols

Amendment Barcode (if applicable)

Name Alisa LaPolt (ah LEE sa)

Job Title Lobbyist

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Street

Phone 850-443-1319

Tallahassee FL 32302
City *State* *Zip*

Email alisa@e gotopsail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Nurses Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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

2/11/16
Meeting Date

1084
Bill Number (if applicable)

Topic fail first / patient access

Amendment Barcode (if applicable)

Name Pam Langford

Job Title President

Address PO Box 180813
Street

Phone

Tallahassee FL 32318
City *State* *Zip*

Email

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

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

Representing HEALS of the South

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Feb 1, 2018
Meeting Date

1084
Bill Number (if applicable)

Topic Step Therapy / Prior Auth

Amendment Barcode (if applicable)

Name Dr. Robert Levin MD

Job Title Physician / Rheumatology

Address 646 Virginia St
Street
Oviedo FL 34698
City *State* *Zip*

Phone 727-734-6631

Email rwlevin@msn.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Society of Rheumatology

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/11
Meeting Date

1984
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name John Langdon

Job Title Governo FL ACP

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Street

Winter Park FL 32789
City *State* *Zip*

Phone 407-415-6057

Email JLANGDON64@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/1/16
Meeting Date

SB 1084
Bill Number (if applicable)

Topic Healthcare Protocols

Amendment Barcode (if applicable)

Name Brittney Hunt

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Email bhunt@flchamber.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/1/16
Meeting Date

1084
Bill Number (if applicable)

Topic Health Care Protocols

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President + CEO

Address 200 W. College 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 Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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THE FLORIDA SENATE

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2/1/16
Meeting Date

SB 1084
Bill Number (if applicable)

Topic Health Care Protocols

Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior VP

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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 Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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2/1/16
Meeting Date

1084
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Rich Roblete

Job Title Deputy Commissioner

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Tallahassee *City* FL *State* 32399 *Zip*

Phone 413-5104

Email _____

Speaking: ☑ For ☐ Against ☐ Information

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

Representing OFR Ins Reg

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

SB 1084
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name DOUGLAS R. MURPHY JR

Job Title F

Address 6260 SW 21ST CT RD
Street

Ocala FLA 34471
City *State* *Zip*

Phone 352-351-0060

Email _____

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FLORIDA MEDICAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1144
INTRODUCER:	Senator Gaetz
SUBJECT:	Certificates of Need for Health Care-related Projects
DATE:	January 27, 2016
REVISED:	

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

I. Summary:

SB 1144 creates a new exemption from the Certificate of Need (CON) review process for any project subject to CON on the condition that the licensee commits to improved access to care for uninsured low-income residents in its service district. If a licensee chooses to use the exemption, the bill requires that the licensee sign an agreement with the Agency for Health Care Administration (AHCA) stating that the licensee will provide charity care to low-income patients within its service district as specified in the bill. The bill also establishes penalties for licensees that fail to provide the required charity care.

II. Present Situation:

Florida's CON Program

Overview

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

Full CON Review Process

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

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

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

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

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

Projects Subject to Full CON Review

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

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

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

Projects Subject to Expedited CON Review

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

Exemptions from CON Review

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

Hospital Exemptions

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

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accepted course of diagnosis or treatment for the condition addressed by a given service, heart transplantation, kidney transplantation, liver transplantation, bone marrow transplantation, lung transplantation, pancreas and islet cells transplantation, heart/lung transplantation, adult open heart surgery, neonatal and pediatric cardiac and vascular surgery, and pediatric oncology and hematology. See s. 408.032(17), F.S., and rule 59C-1.002(41), F.A.C.

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

[15] Section 395.602(2)(g), F.S., defines "swing bed" as a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

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

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

- For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart-surgery program;[18] and
- For the addition of mental health services or beds if the applicant commits to providing services to Medicaid or charity care patients as a level equal to or greater than the district average.

Nursing Home Exemptions

- Adding nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in Florida for at least 65 years on or before July 1, 1994, if the nursing home beds are for the exclusive use of the community residents;
- Adding nursing home beds up to the lesser of 30 total beds or 25 percent of the current facility's beds when a nursing home is being replaced;
- Combining or dividing facilities with nursing home beds;
- Adding nursing home beds up to the greater of 10 beds (20 beds for a designated Gold Seal nursing home) or 10 percent of the number of beds at the licensed facility;
- Replacing a licensed nursing home on the same site or within 5 miles in the same subdistrict if the new nursing home only has the lesser of 30 total beds or 25 percent of the current facility's beds; and
- Consolidating or combining of licensed nursing homes or transferring beds between licensed nursing homes with shared controlling interests within 30 miles and within the AHCA district where both nursing homes are located.

State Run Facility Exemptions

- Building an inmate health care facility that is for the exclusive use of the Department of Corrections (DOC);
- Adding mobile surgical facilities and related health care services under contract with the DOC or a private correctional facility;
- CON requirements for state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs;
- Adding beds in a state mental health facility or state mental health forensic facility; and
- Adding beds in state developmental disabilities centers.

General Exemptions

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

Florida Health Choices Corporation, Inc.

In 2008, the Legislature created the Florida Health Choices Program to address the issue of Florida's uninsured.[19] The Legislature created the Florida Health Choices Corporation

[18] Id.
[19] *See* Chapter 2008-32, Laws of Fla.

(corporation) to administer the program as a private, non-profit, corporation under s. 408.910, F.S. The corporation is to operate in compliance with part III of chapter 112 (Public Officers and Employees) and chapters 119 (Public Records), 286 (Public Business), and 617 (Corporations Not for Profit), F.S.[20]

The corporation is led by a 15-member board of directors, three of whom are ex-officio, non-voting board members. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations (HMOs), prepaid service providers, or any other entity or affiliate or subsidiary of eligible vendors. Conflict of interest provisions govern board member participation.

The program is designed as a single, centralized marketplace for the purchase of health products, including, but not limited to, health insurance plans, HMO plans, prepaid services, and flexible spending accounts. Policies sold as part of the program are exempt from regulation under the Insurance Code and laws governing HMOs. The following entities are authorized to be eligible vendors:

- Insurers authorized under ch. 624, F.S., of the Insurance Code, such as self-insurers, indemnity plans, life and health insurers, church benefit plans, disability, and multi-employer welfare arrangements, and the Florida Healthy Kids Corporation;
- HMOs authorized under part I of ch. 641, F.S., relating to Health Service Programs, including health maintenance organization contracts, limited benefit policies, and other risk bearing coverage, benefits, and products;
- Prepaid limited health service organizations and discount medical plans under ch. 636, F.S.;
- Prepaid health clinics licensed under part II, of ch. 641, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, licensed health care professionals, and other licensed health care providers;
- Provider organizations, including service networks, group practices, and professional associations; and
- Corporate entities providing specific health services.

The corporation's Florida Health Insurance Marketplace (marketplace) currently includes individual health plans, discount plans, and limited benefit plans.

The corporation is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include employers that meet criteria established by the corporation and their individual employees and other individuals meeting criteria established by the corporation.[21]

III. Effect of Proposed Changes:

SB 1144 amends s. 408.036, F.S., to create a new exemption to the CON process for any project subject to CON on the condition that the licensee commits to improved access to care for

[20] Section 408.910(11), F.S.
[21] Section 408.910(4)(a), F.S.

uninsured low-income residents in its service district. In order to demonstrate such commitment, the facility must sign an agreement with the AHCA:

- To provide, once the project is operational and at the end of the first four calendar quarters after the project becomes operational, an amount equal to 1.5 percent of gross revenues earned by the project to the AHCA to be deposited in the Public Medical Assistance Trust Fund.
- To provide, beginning in the fifth calendar quarter after the project becomes operational, charity care in an amount equal or greater than the average for facilities in the same district that provide similar services.
    - The bill defines "charity care" as uncompensated care delivered to uninsured patients with incomes at or below 200 percent of federal poverty level[22] when preauthorized by the licensee and not subject to collection procedures.
    - The bill specifies that the valuation of charity care must be based on Medicaid reimbursement rates.
    - If the licensee provides less charity care than required, the licensee must donate:
        - Payments for charity care provided to residents of the service district pursuant to a written agreement with a charity care provider and equal to or greater than the difference between the value of the charity care provided by the licensee and the average among similar providers; or
        - Payments to Florida Health Choices for health care coverage financial assistance that are equal to or greater than the difference between the value of the charity care provided and the district average among similar providers.
            - These payments must be made in increments sufficient to purchase silver-level health care coverage for an individual for at least 1 year.
            - The individual receiving the assistance must have been uninsured during the previous 12 months.
            - The licensee and Florida Health Choices must cooperate to identify individuals from the service district who are qualified to receive the available assistance.
- To submit reports and data to the AHCA to monitor compliance with the charity care threshold.

The bill also establishes penalties for licensees that are noncompliant with the charity care requirements:

- For the first quarter of noncompliance, the fine is equal to twice the amount of the shortfall and is double for each subsequent quarter up to a maximum of four quarters.
- Following the fifth quarter of noncompliance, the AHCA is required to suspend the licensee's license until the licensee implements a corrective action plan approved by the AHCA.
- If the licensee fails to comply with the corrective action plan, the AHCA is required to revoke the licensee's license.

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

[22] At 200 percent the required annual income equals between $23,540 for individuals and $81,780 for a family of eight, see https://www.healthcare.gov/glossary/federal-poverty-level-FPL/ (last visited on Jan. 27, 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:

SB 1144 may have a positive fiscal impact on Florida residents that would qualify for any new charity care services generated by the provisions in the bill.

The bill may have an indeterminate impact on facilities that are subject to CON review. Such facilities will be able to avoid costs related to the CON process but may incur additional costs related to providing the required charity care or due to penalties assessed by the AHCA for not providing such care as required.

C. Government Sector Impact:

SB 1144 will have an indeterminate fiscal impact on the AHCA.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 408.036 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

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

By Senator Gaetz

1-00103B-16 20161144__

A bill to be entitled

An act relating to certificates of need for health care-related projects; amending s. 408.036, F.S.; providing an exemption from certificate of need review for certain health care-related projects; specifying conditions and requirements for the exemption; requiring a certain agreement between the project applicant and the Agency for Health Care Administration; providing penalties for failure to comply with certain requirements for an exemption to a certificate of need review; providing an effective date.

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

Section 1. Present paragraphs (a) through (t) of subsection (3) of section 408.036, Florida Statutes, are redesignated as paragraphs (b) through (u), respectively, a new paragraph (a) is added to that subsection, present subsections (4) and (5) of that section are redesignated as subsections (5) and (6), respectively, and a new subsection (4) is added to that section, to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(a) Any project conditioned upon a significant, active, and continuing commitment to improved access to care for uninsured and low-income residents of the applicable service district. Such commitment is demonstrated by compliance with the following conditions and requirements which the project applicant must accept in a signed agreement with the agency:

1. The project licensee must contribute, once the project

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1-00103B-16 20161144__

is operational and at the end of each of the first four calendar quarters of the project's operations, an amount equal to 1.5 percent of the gross revenues earned by the exempt project. Contributions shall be made to the agency and deposited in the Public Medical Assistance Trust Fund.

2.a. Beginning in the fifth calendar quarter of the exempt project's operations, the licensee must provide charity care in an amount equal to or greater than the applicable district average among licensed providers of similar services. For purposes of this section, the term "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. The valuation of charity care must be based on Medicaid reimbursement rates.

b. Alternatively, if the licensee provides less charity care than is required by sub-subparagraph a., the licensee must donate:

(I) Pursuant to a written agreement with a charity care provider in the service district, payments for charity care provided to residents of the service district in total amounts equal to or greater than the difference between the value of the charity care provided in sub-subparagraph a. and the applicable district average among licensed providers of similar services; or

(II) Payments to Florida Health Choices for health care coverage financial assistance in total amounts equal to or greater than the difference between the value of the charity care provided in sub-subparagraph a. and the applicable district

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

average among licensed providers of similar services. The payments for financial assistance must be made in increments sufficient to purchase silver-level health care coverage for an individual for at least 1 year. The individual receiving this assistance must have been uninsured during the previous 12 months. The licensee and Florida Health Choices shall cooperate to identify individuals from the service district who are qualified to receive the available assistance.

c. The agreement between the agency and the applicant for an exemption must require the licensee to submit reports and data necessary to monitor compliance with the charity care threshold.

(4) PENALTIES.—A facility licensed based on the exemption established in subsection (3)(a) is subject to the following penalties for noncompliance with its specific commitment to improve access to care for uninsured and low-income persons in the service district:

(a) For the first quarter in which the value of services, donations, and financial assistance falls below the specified threshold, the fine is equal to twice the amount of the shortfall. The fine is doubled in each subsequent quarter of noncompliance up to a maximum of four quarters.

(b) Following a fifth quarter of noncompliance, the exempt license shall be suspended until the licensee implements a corrective action plan that the agency has approved.

(c) Failure by the facility to maintain compliance following the implementation of a corrective action plan shall result in revocation of the exempt license.

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

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on 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
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 11, 2016

I respectfully request that Senate Bill 1144, Certificates of Need for Health Care- related Projects, be placed on the agenda for the Health Policy Committee 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)

2/1
Meeting Date

SB 1144
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Mark Delegal

Job Title General Counsel

Address 315 S. Calhoun St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 224-7000

Email _____

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Safety Net Hospital Alliance

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1144
Bill Number (if applicable)

Topic CON

Amendment Barcode (if applicable)

Name Bill Bell

Job Title General Counsel

Address 306 E College
Street

Phone 222-2800

Tall FL 32301
City *State* *Zip*

Email billbell@fha.org

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)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2.1.2016
Meeting Date

1142
Bill Number (if applicable)

Topic CON Exemptions

Amendment Barcode (if applicable)

Name Paul Ledford

Job Title President + CEO

Address 2000 Apalachee Parkway, Ste 200
Street

Phone 850.878.2632

Tallahassee FL 32301
City *State* *Zip*

Email paul@floridahospices.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Hospice and Palliative Care Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1144 (CoN)
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Bob Asztalos

Job Title Chief Lobbyist

Address 307 W Park Ave
Street

Phone 850-224-3907

Tallahassee FL 32301
City *State* *Zip*

Email baszta los@fhca.org

~~Speaking:~~ ☐ ~~For~~ ☑ ~~Against~~ ☐ ~~Information~~

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

Representing Florida Health Care Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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 1378
INTRODUCER:	Health Policy Committee and Senator Garcia
SUBJECT:	Drug Safety
DATE:	February 1, 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 1378 amends Florida's Prescription Drug Monitoring Program (PDMP) to require pharmacies to offer for sale prescription lock boxes and display a sign indicating the boxes are available there. The bill requires the Department of Health (DOH) to develop and distribute state wide and on the web a pamphlet containing specific information; and requires pharmacists to distribute it at no cost. The bill directs that the act may be cited as "Victoria's Law."

II. Present Situation:

Section 893.055, F.S, creates the PDMP within DOH and requires DOH to design and establish a comprehensive electronic database system to collect controlled substance prescription dispensing information, while not infringing upon the legitimate prescribing or dispensing of controlled substances by a prescriber or dispenser acting in good faith and in the course of professional practice.

The 2014-2015 DOH Prescription Drug Monitoring Report[1] shows that Florida experienced a steady rise in oxycodone-caused death rates from 2005 to a peak in 2010. In 2014, the rate decreased to the lowest since 2006. Recent declines in overdose deaths may be attributed to safer, more effective pain management, changes in state regulatory policies, and promotion of

[1] Florida Dep't of Health, *2014-2015 Prescription Drug Monitoring Program Annual Report* (December 1, 2015), p. 7, *available at* http://www.floridahealth.gov/statistics-and-data/e-forcse/news-reports/_documents/2015-pdmp-annual-report.pdf, (last visited Jan. 28, 2016).

the use of the information maintained in the PDMP.[2] "While Florida has been viewed as the epicenter of the nation's 'pill mill' epidemic, new statistics reflect that the efforts of the Drug Enforcement Administration (DEA) and its federal, state, and local law enforcement partners have made a significant difference in Florida."[3] The PDMP, in combination with changes in regulation, has proven effective at reducing opioid use.[4]

In 2010, Massachusetts became the first state to require pharmacies to carry prescription lock boxes and make available pamphlets on prescription drug abuse when it passed Chapter 283 of the Acts of 2010, adding *Safeguards to the Prescription Monitoring Program and furthering Substance Abuse Education and Prevention*. The act requires all pharmacies in Massachusetts that dispense Schedule II, III, IV, or V prescription drugs to make available lock boxes for sale at each location.[5]

Florida currently does not have any requirement that pharmacies carry prescription lock boxes or make available literature on prescription drug abuse.

III. Effect of Proposed Changes:

CS/SB 1378 amends s. 893.055, F.S., Florida's PDMP, to require pharmacies to offer for sale prescription lock boxes. The bill defines "prescription lock boxes" to mean, "a box or a bag with a locking mechanism that cannot be tampered with or opened without the application of extreme force." The bill requires pharmacies to display a sign on or near the pharmacy counter stating, "Prescription Lock Boxes for Securing Your Prescription Medications Are Available at This Pharmacy."

The bill requires the DOH to develop and distribute a written pamphlet which must contain educational information about the following:

- Precautions regarding the use of pain management prescriptions;
- The potential for misuse and abuse of controlled substances by adults and children;
- The risk of controlled substance dependency and addiction;
- The proper storage and disposal of controlled substances;
- Controlled substance addiction support and treatment resources; and
- Telephone helplines and website links that provide counseling and emergency assistance for individuals dealing with substance abuse.

The DOH must distribute copies of the pamphlet to pharmacies throughout the state and make the contents of the pamphlet available in electronic form on its website. Pharmacists must

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[2] Centers for Disease Control and Prevention. *Injury Prevention & Control: Prescription Drug Overdose*, available at: http://www.cdc.gov/drugoverdose/index.html, (last visited Jan. 28, 2016).
[3] Id. at p. 9.
[4] Rutkow, L., et.al., *Effect of Florida's Prescription Drug Monitoring Program and Pill Mill Laws on Opioid Prescribing and Use*, JAMA Intern Med., 2015:175(10):1642-1649, *available at* http://archinte.jamanetwork.com/article.aspx?articleid=2429105, (last visited Jan. 28, 2016).
[5] See Chapter 283, Section 11, Laws of Mass., 2010. *Safeguards to the Prescription Monitoring Program and furthering Substance Abuse Education and Prevention*, available at: https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter283, (last visited Jan. 28, 2016).

distribute this pamphlet to consumers when dispensing a prescription or controlled substance; and must offer them to consumers in a display. Pharmacies may not charge for the pamphlets.

The bill directs that the act may be cited as "Victoria's Law."

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 1378 requires pharmacies to stock prescription lock boxes, increasing their inventory costs; requires the pharmacist, not an employee of the pharmacy, to distribute the pamphlet to a consumer each time any prescription is dispensed, thereby increasing the pharmacist's workload; and requires additional employee man hours to stock the boxes, and display and distribute the DOH pamphlets.

C. Government Sector Impact:

The bill creates an undetermined, but probably significant, recurring expense to the DOH to develop, print and distribute the required pamphlet throughout the state and on its website.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 893.055 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 1, 2016
The CS directs that the act may be cited as "Victoria's Law." All other provisions remain unchanged.

B. Amendments:

None.

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

860464

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/01/2016	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 14 and 15
insert:
Section 1. This act may be cited as "Victoria's Law."

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Between lines 2 and 3
insert:

860464

An act relating to drug safety; providing a short title; amending s. 893.055,

By Senator Garcia

38-01442A-16 20161378__

A bill to be entitled

An act relating to drug safety; amending s. 893.055, F.S.; requiring pharmacies to offer for sale prescription lock boxes; requiring pharmacies to display a certain sign; defining the term "prescription lock box"; requiring the Department of Health to develop and distribute a pamphlet; requiring the pamphlet to contain certain information; requiring pharmacists to distribute the pamphlet in certain circumstances; prohibiting a pharmacy from charging a fee for the pamphlet; providing an effective date.

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

Section 1. Present subsections (15), (16), and (17) of section 893.055, Florida Statutes, are redesignated as subsections (17), (18), and (19), respectively, and new subsections (15) and (16) are added to that section, to read:

893.055 Prescription drug monitoring program.—

(15) Pharmacies shall offer for sale prescription lock boxes at each store location. Pharmacies shall make customers aware of the availability of the prescription lock boxes by displaying a sign on or near the pharmacy counter which measures at least 4 inches by 5 inches and includes the statement, in a legibly printed font, "Prescription Lock Boxes for Securing Your Prescription Medications Are Available at This Pharmacy." As used in this subsection, the term "prescription lock box" means a box or a bag with a locking mechanism that cannot be tampered with or opened without the application of extreme force.

(16)(a) The department shall develop a written pamphlet relating to controlled substances which includes educational information about the following:

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

38-01442A-16 20161378__

1. Precautions regarding the use of pain management prescriptions.

2. The potential for misuse and abuse of controlled substances by adults and children.

3. The risk of controlled substance dependency and addiction.

4. The proper storage and disposal of controlled substances.

5. Controlled substance addiction support and treatment resources.

6. Telephone helplines and website links that provide counseling and emergency assistance for individuals dealing with substance abuse.

(b) The department shall distribute copies of the pamphlet to pharmacies throughout the state and make the contents of the pamphlet available in electronic form on its website. A pharmacist shall distribute the pamphlet to a consumer when dispensing a prescription or a controlled substance and shall offer them to consumers in a display. Pharmacies may not charge consumers a fee for the pamphlet.

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

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

The Florida Senate

State Senator René García

38th District

District Office:

1490 West 68 Street
Suite # 201
Hialeah, FL. 33014
Phone# (305) 364-3100

January 20, 2016

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

Dear Senator Bean:

Please have this letter serve as my formal request to have **SB 1378: Drug Safety** be heard in the next possible Health Policy Committee Meeting. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

State Senator René García
District 38
RG:AD

CC: Sandra Stovall, Celia Georgiades

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

1378
Bill Number (if applicable)

Topic Drug Safety

Amendment Barcode (if applicable)

Name Steve Geller

Job Title Attorney

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Street

Ft. Lauderdale, FL 33301
City *State* *Zip*

Phone 954-491-1120

Email Steve.Geller@gmlaw.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing David Sigal / Greenspoon Marder

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)
	1378

Amendment Barcode (if applicable)

Topic Prescription lock boxes

Name Melissa Joiner Ramba

Job Title VP of Government Affairs

Address 227 S Adams Street (Street)

Tallahassee FL (City / State)

Zip

Phone

Email: Melissa@FRF.org

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against

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

Representing Florida Retail Federation

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

1378
Bill Number (if applicable)

Topic Drug Safety

Name David Siegel Jackie

Job Title President + CEO, Westgate Resorts

Amendment Barcode (if applicable)

Address 5601 Windhover Dr
Street

Phone 407-256-7700

Orlando FL 32819
City *State* *Zip*

Email david_siegel@wgresorts.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing self - family

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 1442
INTRODUCER:	Health Policy Committee and Senator Garcia
SUBJECT:	Out-of-network Health Insurance Coverage
DATE:	February 2, 2016
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1442 establishes a payment process for emergency services and care provided by out-of-network or nonparticipating providers to insureds of a preferred provider organization (PPO) or an exclusive provider organization (EPO) and prohibits those insurers from collecting or attempting to collect any additional amount or balance billing.

The bill provides that if emergency services are provided, or nonemergency services are provided in a participating facility by a nonparticipating provider and the insured is unable to choose a participating provider:

- The EPO and PPO plans must reimburse nonparticipating providers in the same manner as under the statute governing health maintenance organizations (HMOs) which is the lesser amount of:
  - The provider's charges;
  - The usual and customary provider charges for similar services in the community where the services are provided; or
  - The charge mutually agreed to by the HMO and the provider within 60 days of claim submission.
- The nonparticipating provider may not collect or attempt to collect any additional amount or balance bill the insured, except for any copayments or deductibles.

The bill requires insurers to provide coverage without a prior authorization determination and regardless of whether the provider is a participating provider. Applicable cost sharing must be the same for participating or nonparticipating providers for the same services.

Hospitals will be required to post and maintain information on their websites about which insurers, health maintenance organizations, practitioners, and group practices they contract with so as to put the public on notice.

The bill adds compliance with these new provisions as a condition of licensure for hospitals, surgical centers, and urgent care centers. The bill also adds noncompliance with the provisions by practitioners as grounds for discipline by the Department of Health.

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

II. Present Situation:

Individual purchase insurance coverage generally with the purpose of protecting themselves from future expenses, or in the case of health insurance, the anticipation of unexpected medical bills or large health care costs. Looking at two examples of coverage, preferred provider organization (PPOs) and exclusive provider organization (EPOs) insurers contract with health care providers at set reimbursement rates for covered medical services. Under these types of coverage, an insured individual would only be responsible for any applicable co-payments, co-insurance, or deductibles if services are obtained from a contracted provider. However, if the insured receives services from a non-contracted provider and the provider does not reach a reimbursement agreement with the PPO or EPO insurer, the provider may balance bill the insured for the difference between the cost of the services and what the PPO or EPO paid for the services. If the insured did not knowingly use a non-contracted provider, especially in an emergency services situation, the bill is often not expected and is often called a "surprise bill."

A recent survey by the Kaiser Family Foundation found that among insured, non-elderly adults, nearly seven in ten individuals with unaffordable out-of-network medical bills did not know that the health care provider was not part of their plan's network at the time they received care.[1] In these situations, having insurance did not necessarily protect individuals from unaffordable medical bills. In the same survey, one in five working age, insured Americans reported trouble paying medical bills that caused serious financial challenges and the number was higher within the uninsured, 53 percent.[2] Among the insured, 26 percent said they received unexpected claims denials; and 32 percent said they received care from an out-of-network provider their insurance would not cover.[3] Insured individuals with higher deductible health plans were more likely to

[1] Kaiser Family Foundation, *Surprise Medical Bills* (January 2016), *available at* http://kff.org/private-insurance/issue-brief/surprise-medical-bills/ (last visited Jan. 27, 2016).
[2] Kaiser Family Foundation, *New Kaiser/New York Times Survey Finds One in Five Working Age Americans With Health Insurance Report Problems Paying Medical Bills* (January 5, 2016) *available at* http://kff.org/health-costs/press-release/new-kaisernew-york-times-survey-finds-one-in-five-working-age-americans-with-health-insurance-report-problems-paying-medical-bills/ (last visited Jan. 27, 2016).
[3] Id.

report medical bill issues than those with lower deductible plans (26 percent compared to 15 percent).[4]

For HMO subscribers, providers of emergency and non-emergency services are prohibited from balance billing the subscriber if the service is a covered service. The subscriber is liable for any co-payments, co-insurance, or deductibles. For services to be covered by the HMO, subscribers must generally obtain services from a contracted provider or obtain prior authorization from their HMO.

Current law also prohibits balance billing of HMO subscribers for emergency services obtained from non-contracted providers even when the subscriber is unable to obtain prior authorization for such services. When such services are obtained from a non-contracted provider, the statute establishes the reimbursement rate for the provider as the lesser of the provider's charges, the usual and customary charges for similar services in the community where the services were provided, or the charges mutually agreed to by the HMO and the provider within 60 days of the claim submittal.

Access to Emergency Services and Care

Hospital Care

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.[5] The EMTALA imposes specific obligations on hospitals participating in the Medicare program and which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination to determine if the patient has an emergency medical condition. If an emergency condition exists, the hospital must provide treatment within its service capability to stabilize the patient. If a hospital is unable to stabilize a patient, or upon the patient's request, the hospital must transfer the patient to another appropriate facility. A hospital that violates EMTALA is subject to civil penalty; termination of its Medicare agreement; or civil suit by a patient who suffers personal harm. The EMTALA does not provide for civil action against a hospital's physicians.

Florida law imposes a similar duty.[6] The law requires the Agency for Health Care Administration (AHCA) to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. If the hospital is at capacity or does not provide the required emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is expressly prohibited from basing treatment and care on a patient's insurance status, economic status, or ability to pay. A hospital that violates Florida's access to care statute is subject to administrative penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or

[4] Id.
[5] 42 U.S. Code §1395dd. *Examination and treatment for emergency medical conditions and women in labor.*
[6] *See* s. 395.1041, F.S.

medical staff are subject to civil suit by a patient who suffers personal harm; and may be found guilty of a second degree misdemeanor for a knowing or intentional violation. Physicians who violate the act are also subject to disciplinary action against their license; or civil action by another hospital or physician suffering financial loss.

In February 2015, the Department of the Treasury released a new regulation impacting charitable hospital organizations. The regulation is based on requirements from the Patient Protection and Affordable Care Act of 2010 (PPACA) which requires certain hospitals to conduct a community health needs assessment and adopt an implementation strategy once every 3 years, to establish a written financial assistance policy (FAP), and a written policy related to care for emergency medical conditions.[7] The hospital organization is also required to make reasonable efforts to determine whether an individual is eligible for assistance under a FAP before engaging in extraordinary collection activities.[8] In general, the final regulation requires charitable hospitals to:

- Limit charges to no more than the amounts generally billed to patients with insurance;
- Establish and disclose financial assistance policies;
- Abide by reasonable billing and collection requirements; and
- Perform a community health needs assessment at least every 3 years.

Prehospital Care

The Emergency Medical Transportation Services Act[9] similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The act establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The standards are administered and enforced by the Department of Health. Ambulance services operate pursuant to a license issued by the department and a certificate of public convenience and necessity issued from each county in which the provider operates.[10] A licensee may not deny a person needed prehospital treatment or transport for an emergency medical condition.[11] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[12]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to the ambulance service provider to ensure that the patient is transported to a facility that offers the type and level of care appropriate to the patient's medical condition, with separate protocols required for stroke patients.[13] An exception to the general requirement, trauma alert patients are required by statute to be transported to an approved trauma center.[14]

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[7] Internal Revenue Service, *Internal Revenue Bulletin: 2015-5, Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return,* (February 2, 2015) *available at* https://www.irs.gov/irb/2015-5_IRB/ar08.html (last visited Jan. 27, 2016).
[8] Id.
[9] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.)
[10] Section 401.25(2)(d), F.S.
[11] Section 401.45, F.S.
[12] Section 401.411, F.S.
[13] Section 395.3041(3), F.S.
[14] Section 395.4045, F.S.

Federal Patient Protection and Affordable Care Act (PPACA)

On March 23, 2010, President Obama signed into law Public Law No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, amending PPACA. The PPACA provided fundamental changes to the U.S. health care system by requiring health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, and other requirements.

Essential Health Benefits

The PPACA requires coverage offered in the individual and small group markets to provide the following categories of services[15] (essential health benefits):

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[16]

Emergency Room Coverage[17]

On June 28, 2010, the Department of Health and Human Services issued final regulations relating to coverage for emergency services. Such coverage for emergency services is not subject to prior authorization, regardless of whether the provider is a network or participating provider. Services provided by out-of-network providers must be provided with cost sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. Regulations specify minimum reimbursement that plans must pay a non-network provider for emergency services.[18] Plans are required to pay out-of-network providers a reasonable rate, which is defined to be the greatest of the following:

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[15] 42 U.S.C. 300gg-6.

[16] These provisions do not apply to grandfathered plans, as defined in 42 U.SC. s. 18011. Pursuant to s. 627.402, F.S., a "grandfathered health plan" has the same meaning as provided in 42 U.S.C. s. 18011, subject to the conditions for maintaining status as a grandfathered health plan specified in regulations adopted by the federal Department of Health and Human Services in 45 C.F.R. s. 147.140. "A non-grandfathered health plan" is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6561(5)(b)-(e), F.S.

[17] 42 U.S.C. s. 300gg-19A.

[18] 45 C.F.R. s. 147.138(b).

- The amount negotiated with in-network providers for the emergency service furnished (if the plan has more than one negotiated amount with providers for a particular service, the basis for payment would be the median amount);
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing; or
- The amount that would be paid under Medicare for the emergency services.

Subsequently, on September 20, 2010, the Centers for Medicare and Medicaid Services issued guidance relating to coverage for emergency services.[19] If a state law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations. Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if state law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.[20]

Balance Billing

At some point, many insureds will end up in an emergency room of a hospital. Even if the hospital is a network provider, physicians practicing at that network hospital may or may not be participating in the same insurance network. In many instances, physicians practicing within a hospital are not employees of the hospital and do not participate in the same insurance plans or HMOs as the hospital.

Generally, insureds of PPO and EPO plans may access specialists within a network without a prior referral or authorization from the insurer. However, if an insured obtains services from an out-of-network provider, and that provider does not reach an agreement with the insurer on a reimbursement amount for the service, the provider can balance bill the patient for the difference between the billed charges of the provider and the amount the insurer paid on the claim. There is no prohibition against a non-network provider balance billing an insured covered by a health insurance policy under ch. 627, F.S.

If an HMO is liable for services rendered, the provider may not balance bill for covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[21] However, an HMO is liable for services rendered if the provider obtains authorization from the

[19] *See* Centers for Medicare and Medicaid Services, The Center for Consumer and Insurance Oversight, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html#Out-Of-Network Emergency Services (last visited Jan. 28, 2016).
[20] *Id.*
[21] Sections 641.315(1) and 641.3154(1), F.S.

HMO prior to providing services. Thus, a provider can balance bill if authorization is denied or if the provider does not seek prior authorization.[22]

Balance billing is prohibited currently for services under Medicaid,[23] workers compensation insurance,[24] by an exclusive provider who is part of an EPO,[25] or by a provider who is under contract with a prepaid limited service organization.[26]

Agency for Health Care Administration

The AHCA licenses and regulates hospitals, ambulatory surgical centers, home health agencies, clinical laboratories, nursing homes, assisted living facilities, and all other types of health care providers under ch. 395, F.S. The AHCA is responsible for inspections and investigations as part of the licensure process, including inspections to investigate emergency access complaints.[27]

The AHCA also regulates quality of care provided by HMOs and EPOs. Before receiving a certificate of authority from the Office of Insurance Regulation (OIR), an HMO or EPO must receive a Health Care Provider Certificate from the AHCA pursuant to part III of ch. 641, F.S.[28] As part of the review process to receive a Health Care Provider Certificate for any given area, the plans must demonstrate the ability to provide quality of care consistent with the prevailing standards of care.[29]

Office of Insurance Regulation

The OIR licenses and regulates the activities of insurers, HMOs, and other risk bearing entities.[30]

Generally, an HMO member (subscriber) must use the HMO's network of health care providers in order for the HMO to provide payment of benefits. Unlike other health plan types, services are covered only if a subscriber sees a provider within the HMO's network, except in the case of an emergency. Florida law requires HMO's to provide coverage without prior authorization for emergency care, based on a determination by a hospital physician or other personnel, provided by either a contract or non-contract provider.[31] If an HMO is liable for services rendered to a subscriber by a provider, contracted or non-contracted, the HMO is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.[32] The use of a

[22] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited Jan. 28, 2016).
[23] Section 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with Provider General Handbook, which prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (Core Provisions of the MMA Contract - Nov. 1, 2015 version, pp. 104-105) establishes minimum requirements for contracts between the managed care plans and its contracted providers. The contract prohibits the provider from seeking payment from the enrollee for any covered services, except for co-payments, and to look only to the managed care plan for payment.
[24] Section 440.13(13)(a), F.S.
[25] Section 627.6472(4)(e), F.S.
[26] Section 636.035(3)-(4), F.S.
[27] Section 395.0161(1)(e), F.S.
[28] Sections 641.21(1) and 641.48, F.S.
[29] Section 641.495, F.S.
[30] Section 20.121(3)(a), F.S.
[31] Section 641.513, F.S.
[32] Section 641.3154(1), F.S.

health care provider outside the HMO's network, except for emergency care, generally results in the HMO limiting or denying payment of benefits for non-network services rendered to the member.[33] Further, a provider, regardless of whether contracted or not with the HMO, may not collect or attempt to collect money from a subscriber of an HMO for payment of services for which the HMO is liable, if the provider in good faith knows or should know that the HMO is liable.[34]

A PPO or network is a group of licensed health care providers the insurer has directly or indirectly contracted for alternative or reduced rates of payment.[35] An exclusive provider is a provider of health care, or a group of providers of health care, that has entered into a written agreement with an insurer to provide benefits under a health insurance policy.[36]

In an EPO, an insurance company contracts with hospitals, physicians, and other medical facilities. Insureds of an EPO must use the contracted hospitals or providers to receive covered benefits from this type of plan. Providers within an EPO or PPO network are prohibited from billing or otherwise seeking reimbursement from or recourse against any policyholder. Insurers issuing exclusive provider contracts must cover services provided by out-of-network providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.

Insurers and HMOs may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments.[37] The HMOs must pay non-contract providers specified minimum reimbursement for emergency services.[38]

The Florida Insurance Code requires insurers and HMOs to provide a description of coverage, benefits, coverage, and limitations of a policy or contract. This document may include an outline of coverage explaining the principal exclusions and limitations of the policy.[39]

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program was established within the AHCA by the 2000 Legislature to provide assistance to contracted and non-contracted providers and HMOs, insurers, prepaid health clinics, EPOs, and Medicaid prepaid health plans for resolution of claim disputes that are not resolved by the provider and the plan.[40]

Section 408.7057, F.S., requires the AHCA to contract with a third party resolution organization to timely review and consider claim disputes and to submit recommendations to the AHCA. The

[33] Section 641.31(38), F.S., authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at time of service and without referral, a noncontract provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a noncontract provider.
[34] Section 641.3154(4), F.S.
[35] Section 627.6471, F.S.
[36] Section 627.6472, F.S.
[37] Sections 627.6405 and 641.31(12), F.S.
[38] Section 641.513, F.S.
[39] Section 627.642, F.S.
[40] Chapter 2000-252, Laws of Fla.

AHCA's responsibility is to issue a final order adopting the recommendation of the resolution organization. The AHCA entered into a contract with MAXIMUS to review claim disputes and MAXIMUS has been reviewing claims disputes since May 1, 2001. The cost of the program is borne by the users of the program. The non-prevailing entity in AHCA's final order must pay the review costs. In cases where both parties prevail in part, the review cost must be shared. The review costs are determined by MAXIMUS and depend largely on the complexity of the cases submitted.

Eligible Claims.[41] The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed health care providers, HMOs, EPOs, PHPs, major medical expense health insurance policies offered by a group or an individual health insurer, and PPOs:

- Claim disputes for services rendered after October 1, 2000.
- Claim disputes related to payment amounts only (provider disputes payment amounts received or HMO disputes payback amounts).
- Hospital and physicians are required to aggregate claims (for one or more patients for same insurer) by type of service to meet certain thresholds:[42]
    - Hospital Inpatient Claims (contracted providers) $25,000
    - Hospital Inpatient Claims (non-contracted providers) $10,000
    - Hospital Outpatient Claims (contracted providers) $10,000
    - Hospital Outpatient Claims (non-contracted providers) $3,000
    - Physicians $500
    - Rural Hospitals None
    - Other Providers None

The following types of claims are ineligible for the program:

- Claims for less than minimum amounts listed above for each type of service.
- Claim disputes that are the basis for an action pending in State/Federal court.
- Claims disputes that are subject to an internal binding managed care organization's resolution process for contracted enter into prior to October 1, 2000.
- Claims solely related to late payment and/or late processing.
- Interest payment disputes.
- Medicare claim disputes that are part of Medicare managed care internal grievance or that qualify for Medicare reconsideration appeal.
- Claims related to health plans not regulated by the state of Florida.
- Claims filed more than 12 months after final determination by the health plan or provider.

Claims Disputes Caseload. During 2014, only 25 claim disputes were filed for consideration. Nine of the 25 claim disputes were accepted as eligible claims for review. At year end, one case was settled, four cases were under review, and the plans opted out of the remaining four cases.[43]

[41] Section 408.7057, F.S., requires the AHCA to submit an annual report to the Governor and the Legislature on the status of the program. *See* Agency for Health Care Administration. *Statewide Provider and Health Plan Claim Dispute Resolution Program Annual Report - February 2015* (on file with the Senate Committee on Health Policy).
[42] Claim thresholds are established by Rule 59A-12.030, F.A.C.
[43] Id.

III. Effect of Proposed Changes:

Section 1 - amends s. 395.003, F.S., to require compliance by hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers with the provisions of ss. 627.64194, and 641.513, F.S., as a condition of licensure. Section 627.64194, F.S., is a new section of law that requires coverage for out-of-network emergency services by PPO and EPO plans.

Section 2 -amends s. 395.301, F.S., to add website posting requirements for hospitals. A hospital must post the following information:

- The names and hyperlinks for direct access to the websites of all health insurers and health maintenance organizations (HMOs) for which the hospitals contracts as a network provider or a participating provider;
- A statement that:
  - Services provided in the hospital by health care practitioners may not be included in the hospital's charges;
  - Health care practitioners who provide services in the hospital may or may not participate in the same health insurance plans as the hospital;
  - Prospective patients should contact the health care practitioner arranging for the services to determine the health care plans in which the health care practitioner participates;
- As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and practice groups under contract with the hospital to provide services in the hospital and how to contact them to determine in which health insurers and HMOs they are participating providers.

Section 3 - amends s. 456.072, F.S., to add as grounds for discipline of a licensee of the Department of Health failure to comply with the provision s. 627.64191, F.S., or s. 641.513, F.S., with such frequency as to constitute a general business practice.

Section 4- creates s. 627.64194, F.S., to expand protection for out-of-network coverage of emergency services to subscribers of PPO and EPO networks. Under this section, the following terms are defined:

- *Emergency services* means the services and care to treat an emergency medical condition, as defined in s. 641.47, F.S.[44] For purposes of this section, the term includes emergency transportation and ambulance services, to the extent permitted by applicable state and federal law.
- *Facility* means a licensed facility as defined in s. 395.002(16), F.S.,[45] or an urgent care center as defined in s. 395.002(30), F.S.[46]

[44] "Emergency services and care" means medical screening, examination, and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency condition within the service capability of a hospital.

[45] "Licensed facility" means a hospital, ambulatory surgical center, or mobile surgical center licensed in accordance with this chapter.

[46] "Urgent care center" means a facility or clinic that provides immediate but not emergent ambulatory medical care to patients. The term includes an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent care is provided. The term also includes: (a) An offsite facility of a facility licensed under this chapter, or a joint venture between a facility licensed under this chapter and a provider licensed under chapter 458 or chapter 459, that does not require a patient to make an appointment and is presented to the

- *Nonemergency services* means the services and care to treat a condition other than an emergency condition, as defined in s. 395.002(8), F.S.[47]
- *Nonparticipating provider* means a provider who is not a "preferred provider" as defined in s. 627.6471, F.S.,[48] an "exclusive provider" as defined in s. 627.6472, F.S.,[49] or a facility licensed under ch. 395, F.S. A provider that is employed by a facility licensed under ch. 395, F.S., and this is not a "preferred provider" or an "exclusive provider" is a nonparticipating provider.
- *Participating provider* means a "preferred provider" as defined in s. 627.6471, F.S., and an "exclusive provider" as defined in s. 627.6472, F.S., but not a facility licensed under ch. 395, F.S.
- *Insured* means a person who is covered under an individual or group health insurance policy delivered or issued for delivery in this state by an insurer authorized to transact business in this state.

The bill requires the insurer to be solely responsible for payment to a non-participating provider for emergency services that:

- May not require a prior authorization determination;
- Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider; and
- May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

The insurer is liable for payment of fees to a non-participating provider, not the insured, other than applicable copayments and deductibles, for medical services and care that are:

- Not emergency services and care as defined in s. 395.002, F.S.;
- Provided in a facility licensed under ch. 395, F.S., which has a contract with the insurer; and
- Where the insured has no ability and opportunity to choose a participating provider at the facility.

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general public in any manner as a facility where immediate but not emergent care is provided. (b) A clinic organization that is licensed under part X of chapter 400, maintains three or more locations using the same or similar name, does not require a patient to make an appointment, and holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided.

[47] "Emergency medical condition" means" (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1. Serious jeopardy to patient health, including a pregnant woman or fetus. 2. Serious impairment to bodily functions. 3. Serious dysfunction of any bodily organ or part. (b) With respect to pregnant women: 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery. 2. That a transfer may pose a threat to the health and safety of the patient or fetus; or 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

[48] "Preferred provider" means any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment, which shall include any health care provider listed in s. 627.419(3) and (4) and shall provide reasonable access to such health care providers.

[49] "Exclusive provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under his section, which agreement shall include any health care provider listed in s. 627.419(3) and (4) and shall provide reasonable access to such health care providers.

If the insured makes an informed affirmative decision to choose a nonparticipating provider instead of a participating provider at the facility, the provisions for payment by the insurer above do not apply.

An insurer must reimburse the nonparticipating provider for services of an insured in the manner specified under s. 641.513(5), F.S.,[50] and within the specified timeframes of s. 627.6131, F.S.[51] The nonparticipating provider may not collect, directly or indirectly, any excess amount except for copays or deductibles.

If there is a dispute as to the amount of the reimbursement to the nonparticipating provider of either emergency or nonemergency services, the dispute must be resolved in either a court of competent jurisdiction or by the voluntary dispute resolution process in s. 408.7057, F.S.

Section 5- amends s. 627.6471, F.S., relating to insurance contracts and policies for preferred provider networks. The bill requires any insurer issuing a policy under this section to provide each policyholder and certificateholder with a current list of preferred providers and to make the list available on its website. The list must be ordered by specialty, where applicable, and include the names, addresses, and telephone numbers of all participating providers, including facilities, and in the case of physicians, their board specialties, languages spoken, and affiliations with local hospitals. The website must be updated on at least a calendar month basis with additions and terminations of providers from the network and any changes in physician hospital affiliations.

Any health insurance policy issued after January 1, 2017, under this section must also include the following specific disclosure to policyholders:

> WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contracting your insurer or agent directly.

[50] Under this statute, the nonparticipating provider may be reimbursed for emergency services in an amount which is the lesser of : the provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; or he charge mutually agreed to by the health maintenance organization and the provider within 60 days of submittal of the claim.

[51] Typically, with an electronically submitted claim, an insurer shall pay the claim within 20 days after receipt or notify the provider or designee if the claim is to be denied or contested.

Section 6 - provides an effective date of October 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:

Patients covered by an EPO or PPO will not be subject to balance billing for emergency services provided by nonparticipating providers. For non-emergency services in facilities licensed under ch. 395, F.S., patients will also not be subject to balance billing if they have no opportunity to select their providers.

Hospitals will be required to post and maintain information on their websites about which insurers, HMOs, practitioners, and group practices they contract with so as to put the public on notice. The hospitals may incur some costs to comply with this notice requirement on an ongoing basis as information must be updated on a monthly basis once implemented.

To the extent that the options provided for determining reimbursement of an out-of-network emergency services claim are different from how an insurer or health care provider currently is reimbursed, the formula for reimbursement may have a fiscal impact on the affected party.

C. Government Sector Impact:

CS/SB 1442 adds a new licensing condition for the AHCA to consider when inspecting hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers which may involve additional time to complete an inspection.

The Department of Health may experience additional workload with respect to the new disciplinary grounds.

VI. Technical Deficiencies:

In Section 2, Subsection (13), subparagraph (c), clarification may be needed for the type of information the hospital is required to post on its website relating to contact information for its contracted health care practitioners and health care practice groups and health insurers and HMOs to distinguish from the information being required under subparagraph (a) of this same subsection.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.003, 395.301, 456.072, and 627.6471.

This bill creates section 627.64194 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 1, 2016:
The CS requires:

- Hospitals to post on its website a listing of its contractual relationships with insurers and HMOs, practitioners and practice groups along with contact information and hyperlinks;
- Application of the current HMO reimbursement statute for out of network emergency services for PPO and EPO patients;
- The parties to seek resolution through a court of competent jurisdiction or through the voluntary resolution dispute process for disputes over the reimbursement amount for emergency or nonemergency fees;
- Any issuer of health insurance products in this state for reduced rates of payment to make a list of preferred providers available on its website, with monthly updates; and
- Any issuer of health insurance products in this state for reduced rates of payment to provide additional warning and disclosure language regarding limited benefits and payment when nonparticipating providers are used beginning January 1, 2017.

The CS includes emergency transportation and ambulance services in the definition of emergency services.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/01/2016	.	
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The Committee on Health Policy (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (d) is added to subsection (5) of section 395.003, Florida Statutes, to read:

395.003 Licensure; denial, suspension, and revocation.—

(5)

(d) A hospital, ambulatory surgical center, specialty hospital, or urgent care center shall comply with the provisions

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of ss. 627.64194 and 641.513 as a condition of licensure.

Section 2. Subsection (13) is added to section 395.301, Florida Statutes, to read:

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

(13) A hospital shall post on its website:

(a) The names and hyperlinks for direct access to the websites of all health insurers and health maintenance organizations for which the hospital contracts as a network provider or a participating provider.

(b) A statement that:

1. Services provided in the hospital by health care practitioners may not be included in the hospital's charges;

2. Health care practitioners who provide services in the hospital may or may not participate with the same health insurance plans as the hospital;

3. Prospective patients should contact the health care practitioner arranging for the services to determine the health care plans in which the health care practitioner participates.

(c) As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and practice groups that the hospital has contracted with to provide services in the hospital and instruction on how to contact these health care practitioners and practice groups to determine the health insurers and health maintenance organizations for which the hospital contracts as a network provider or a participating provider.

Section 3. Paragraph (oo) is added to subsection (1) of section 456.072, Florida Statutes, to read:

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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) Failing to comply with the provisions of s. 627.64194 or s. 641.513 with such frequency as to constitute a general business practice.

Section 4. Section 627.64194, Florida Statutes, is created to read:

627.64194 Coverage requirements for services provided by nonparticipating providers.—

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

(a) "Emergency services" means the services and care to treat an emergency medical condition, as defined in s. 641.47. For purposes of this section, the term includes emergency transportation and ambulance services, to the extent permitted by applicable state and federal law.

(b) "Facility" means a licensed facility as defined in s. 395.002(16) or an urgent care center as defined in s. 395.002(30).

(c) "Nonemergency services" means the services and care to treat a condition other than an emergency medical condition, as defined in s. 395.002(8).

(d) "Nonparticipating provider" means a provider who is not a "preferred provider" as defined in s. 627.6471, an "exclusive provider" as defined in s. 627.6472, or a facility licensed under chapter 395. A provider that is employed by a facility licensed under chapter 395, and that is not a "preferred provider" as defined in s. 627.6471 or an "exclusive provider"

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as defined in s. 627.6472, is a nonparticipating provider.

(e) "Participating provider" means a "preferred provider" as defined in s. 627.6471 or an "exclusive provider" as defined in s. 627.6472, but not a facility licensed under chapter 395.

(f) "Insured" means a person who is covered under an individual or group health insurance policy delivered or issued for delivery in this state by an insurer authorized to transact business in the state.

(2) An insurer is solely liable for payment of fees to a nonparticipating provider of emergency services provided to an insured in accordance with the terms of the health insurance policy. Such insured is not liable for payment of fees to a nonparticipating provider of emergency services other than applicable copayments and deductibles. An insurer must provide coverage for emergency services that:

(a) May not require prior authorization.

(b) Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider.

(c) May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

(3) An insurer is solely liable for payment of fees to a nonparticipating provider of nonemergency services provided to an insured in accordance with the terms of the health insurance policy. Such insured is not liable for payment of fees to a nonparticipating provider, other than applicable copayments and deductibles, for nonemergency services:

(a) That are provided in a facility that has a contract for

the nonemergency services with the insurer which the facility would be otherwise obligated to provide under contract with the insurer; and

(b) Where the insured has no ability and opportunity to choose a participating provider at the facility.

If the insured makes an informed affirmative decision to choose a nonparticipating provider instead of a participating provider who is available at the facility to treat the insured, the provisions of this subsection do not apply.

(4) An insurer must reimburse a nonparticipating provider for services under subsections (2) and (3) as specified in s. 641.513(5) within the applicable timeframe provided by s. 627.6131.

(5) A nonparticipating provider of emergency services as provided in subsection (2) or nonemergency services as provided in subsection (3) may not be reimbursed an amount greater than the amount provided in subsection (4) and may not collect or attempt to collect from the patient, directly or indirectly, any excess amount except for copays and deductibles.

(6) A dispute with regard to the amount of reimbursement owed to the nonparticipating provider of emergency or nonemergency services as provided in subsection (4) must be resolved in a court of competent jurisdiction or by the voluntary dispute resolution process in s. 408.7057.

Section 5. Subsection (2) of section 627.6471, Florida Statutes, is amended, and a new subsection (7) is added to that section, to read:

627.6471 Contracts for reduced rates of payment;

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limitations; coinsurance and deductibles.—

(2) Any insurer issuing a policy of health insurance in this state, which insurance includes coverage for the services of a preferred provider, must provide each policyholder and certificateholder with a current list of preferred providers and must make the list available on its website. The list must include, where applicable and reported, a listing by specialty of the names, addresses, and telephone numbers of all participating providers, including facilities; and in the case of physicians, board certifications, languages spoken, and any affiliations with participating hospitals. Information posted to the insurer's website must be updated on at least a calendar-month basis with additions or terminations of providers from the insurer's network or reported changes in physician's hospital affiliations ~~must make the list available for public inspection during regular business hours at the principal office of the insurer within the state~~.

(7) Any policy issued after January 1, 2017 under this section must include the following disclosure: "WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT. Participating providers have agreed to accept discounted payments for services

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with no additional billing to you other than coinsurance and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

Section 6. This act shall take effect October 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 out-of-network health insurance coverage; amending s. 395.003, F.S.; requiring hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with certain provisions as a condition of licensure; amending s. 395.301, F.S.; requiring a hospital to post certain information on its website regarding its contracts with health insurers, health maintenance organizations, and health care practitioners and practice groups and a specified statement to patients and prospective patients; amending s. 456.072, F.S.; adding a ground for discipline of referring health care providers by the Department of Health; creating s. 627.64194, F.S.; defining terms; specifying requirements for coverage provided by an insurer for emergency services; providing that an insurer is solely liable for payment of certain fees to a


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provider; providing that an insured is not liable for payment of certain fees; providing limitations and requirements for reimbursements by an insurer to a nonparticipating provider; providing applicability; authorizing a nonparticipating provider or insurer to initiate action in a court of competent jurisdiction or through voluntary dispute resolution; amending s. 627.6471, F.S.; requiring an insurer that issues a policy including coverage for the services of a preferred provider to post certain information about participating providers on its website; requiring a specified disclosure to be included in policies providing coverage for the services of a preferred provider; providing an effective date.

By Senator Garcia

38-00445C-16 20161442__

A bill to be entitled

An act relating to out-of-network health insurance coverage; amending s. 395.003, F.S.; requiring hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with certain provisions as a condition of licensure; amending s. 456.072, F.S.; adding a ground for discipline of referring health care providers by the Department of Health; creating s. 627.64194, F.S.; defining terms; specifying requirements for coverage provided by an insurer for emergency services; providing that an insurer is solely liable for payment of certain fees to a provider; providing limitations and requirements for reimbursements by an insurer to a nonparticipating provider; requiring a specified insurer to provide a disclosure to its insureds under certain circumstances; requiring a specified facility to provide a written disclosure and estimate to patients under certain circumstances; requiring a nonparticipating provider to provide a written disclosure to a patient under certain circumstances; providing that a patient is not liable for certain charges if a nonparticipating provider fails to provide such disclosure; amending s. 641.513, F.S.; revising the methodology for determining health maintenance organization reimbursement amounts for emergency services and care provided by certain providers; providing an effective date.

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

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

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

38-00445C-16 20161442__

section 395.003, Florida Statutes, to read:

395.003 Licensure; denial, suspension, and revocation.—

(5)

(d) A hospital, ambulatory surgical center, specialty hospital, or urgent care center shall comply with the provisions of ss. 627.64194 and 641.513 as a condition of licensure.

Section 2. 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) Serving as an officer or director of a business entity, or group practice as defined in s. 456.053, and failing to comply with the provisions of s. 627.64194 or s. 641.513 with such frequency as to constitute a general business practice.

Section 3. Section 627.64194, Florida Statutes, is created to read:

627.64194 Coverage for out-of-network services.—

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

(a) "Coverage for emergency services" means the coverage provided by a health insurance policy for "emergency services and care" as defined in s. 641.47.

(b) "Participating provider" means a "preferred provider" as defined in s. 627.6471 and an "exclusive provider" as defined in s. 627.6472, including provider facilities.

(2) An insurer must provide coverage for emergency services that:

(a) May not require a prior authorization determination.

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

(b) Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider.

(c) May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

(3) An insurer is solely liable for payment of fees to a provider and an insured is not liable for payment of fees to a provider, other than applicable copayments and deductibles, for medical services and care that are:

(a) Not emergency services and care as defined in s. 395.002;

(b) Provided in a facility licensed under chapter 395 which has a contract with the insurer; and

(c) Provided by a nonparticipating provider where the insured has no ability and opportunity to choose a participating provider at the facility.

(4) A nonparticipating provider may not be reimbursed an amount greater than that provided under subsection (5) and may not collect or attempt to collect, directly or indirectly, any excess amount.

(5) An insurer must reimburse a nonparticipating provider as provided in subsections (2) and (3) the greater of the following:

(a) The amount negotiated with an in-network provider in the same community where the services were provided, excluding any in-network copayment or coinsurance imposed pursuant to the policy;

(b) The usual and customary reimbursement received by a

provider for the same service in the community where the service was provided, reduced only by any coinsurance amount or copayment that applies to the provider; or

(c) The amount that would be paid under Medicare for the service, reduced only by any coinsurance amount or copayment that applies to the provider.

(6) An insurer issuing a health insurance policy that provides coverage for medical and related services within a facility licensed under chapter 395 shall disclose to its insureds whether the facility contracts with nonparticipating providers. Such disclosure may be displayed on the insurer's member website or directly distributed by the insurer to its insureds.

(7) Upon scheduling services or admitting a patient for treatment of a condition other than an emergency medical condition, a facility licensed under chapter 395 shall disclose, in writing, to the patient all of the following information:

(a) The names, office addresses, and telephone numbers of providers who will treat the patient, and which of those providers are nonparticipating providers. The facility shall identify only those providers who are reasonably expected to provide specific medical services and treatment scheduled to be received by the insured.

(b) A statement that nonparticipating providers may directly bill patients with health insurance for services rendered within the facility, even after the nonparticipating provider has been reimbursed by the patient's insurer.

(8) A nonparticipating provider who treats a patient for a condition other than an emergency medical condition at a

facility licensed under chapter 395 shall disclose, in writing, to the patient before providing medical services whether the patient will be billed directly for such services and shall provide a written estimate of the amount that will be billed directly to the patient. A patient is not liable for any charges, other than applicable copayments or deductibles, billed to the patient by a nonparticipating provider who fails to disclose such information and provide the required estimate.

Section 4. Subsection (5) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.—

(5) Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the greater ~~lesser~~ of:

(a) The Medicare allowable rate ~~provider's charges~~;

(b) The usual and customary reimbursement received by a provider ~~charges~~ for the same service ~~similar services~~ in the community where the service was ~~services were~~ provided; or

(c) The amount negotiated with a provider under a contract with the health maintenance organization in the same community where the emergency services were provided, excluding any copayment payable by the subscriber pursuant to the contract ~~charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim~~.

Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

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

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

The Florida Senate

State Senator René García

38th District

District Office:

1490 West 68 Street
Suite # 201
Hialeah, FL. 33014
Phone# (305) 364-3100

January 20, 2016

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

Dear Senator Bean:

Please have this letter serve as my formal request to have **SB 1442: Out-of-network Health Insurance Coverage**, be heard in the next possible Health Policy Committee Meeting. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

State Senator René García
District 38
RG:AD

CC: Sandra Stovall, Celia Georgiades

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-2016
Meeting Date

SB 1442
Bill Number (if applicable)

Topic OUT OF NETWORK HEALTH INSUR COVERAGE

Amendment Barcode (if applicable)

Name JOE SCIALDONE

Job Title EMS BILLING MGR - FL AMBULANCE ASSOC. REP.

Address 6575 NORTH W ST.
Street

PENSACOLA FL 32505
City *State* *Zip*

Phone 850-471-6507

Email JASCIALDONE@MYESCAMBIA.COM

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FL AMBULANCE 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)

2/1/16
Meeting Date

1442
Bill Number (if applicable)

Topic Balance Billing

Amendment Barcode (if applicable)

Name Ron Watson

Job Title Lobbyist

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

Phone 850 567-1202

Email watson.strategies@comcast.net

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida CHAIN

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/2/16
Meeting Date

1442
Bill Number (if applicable)

Topic SB 1442

976590
Amendment Barcode (if applicable)

Name Stephen Ecenia

Job Title

Address P.O. Box 551
Street

Tallahassee FL 32
City *State* *Zip*

Phone 850-681-6788

Email SteveE@renphlaw.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing HCA

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)

(7)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

SB 1442
Bill Number (if applicable)

Topic Out-of-network Health Insurance Coverage

Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior VP

Address 516 N. Adams St
Street

Phone 850-224-7173

Tallahassee FL 32312
City *State* *Zip*

Email bbevis@aif.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1442
Bill Number (if applicable)

Topic OON Health Ins Coverage

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President and CEO

Address 200 W. College Ave.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-386-2904

Email Audrey@fahp.net

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL Assoc. of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1442
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Rich Roblett

Job Title Deputy Commissioner

Address 300 E Gaines
Street

Tallahassee
City *State* *Zip*

Phone 850-413-5104

Email _____

Speaking: ☑ For ☐ Against ☐ Information

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

Representing OIR

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1442
Bill Number (if applicable)

Topic Out of Network Health Insurance Coverage

Amendment Barcode (if applicable)

Name SharRon James

Job Title Insurance Consumer Advocate

Address Pepper Bldg 776
Street

Tallahassee FL
City *State* *Zip*

Phone (850) 413-2868

Email Sharon.james@myfloridacfo.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Office of Insurance Consumer Advocate

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

1442
Bill Number (if applicable)

Topic Balance Billing

Amendment Barcode (if applicable)

Name Tim Nungesser

Job Title Legislative Director

Address 110 E. Jefferson St.
Street

Phone 850-445-5360

Tallahassee FL 32301
City *State* *Zip*

Email tim.nungesser@nfib.org

Speaking: ☒ For ☐ Against ☐ Information

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

Representing NFIB

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/11/16 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 1442

Meeting Date *Bill Number (if applicable)*

Amendment Barcode (if applicable)

Topic Balance Billing

Name Bill Bell

Job Title General Counsel

Address 306 College Ave *Street*

Phone 222-9800

Tlh FL 32301 *City* *State* *Zip*

Email billbe@fhcn.org

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Hospital / FHCN

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2-1-16
Meeting Date

SB 1442
Bill Number (if applicable)

Topic Balance Billing/Emergency Services

976590
Amendment Barcode (if applicable)

Name DANIEL BRENNAN MD MD

Job Title emergency physicians

Address 340 N LAKE SYBELIA DR
Street

MAITLAND FL 32751
City *State* *Zip*

Phone 407 227 6665

Email DANIEL.BRENNAN@EBCF online.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FLORIDA COLLEGE of EMERGENCY PHYSICIANS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/1/16
Meeting Date

1442
Bill Number (if applicable)

Topic BALANCE BILLING

Amendment Barcode (if applicable)

Name PAT KOSTIC

Job Title EMS MANAGER

Address 6575 NORTH "W" ST.
Street

Phone 850-471-6426

PENSACOLA FL 32505
City *State* *Zip*

Email PKOSTIC@myESCAMBIA.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing ESCAMBIA COUNTY EMS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/1/2016
Meeting Date

SB 1442
Bill Number (if applicable)

Topic Balance Billing

Amendment Barcode (if applicable)

Name Cari Roth

Job Title

Address 215 S. Monroe Street Suite 815
Street

Phone 850/999-4100

Tallahassee FL 32301
City *State* *Zip*

Email croth@dennmead.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fla. Ambulance Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2.1.16
Meeting Date

SB 1442
Bill Number (if applicable)

Topic Out of Network Health Insurance Coverage

Amendment Barcode (if applicable)

Name Leon Salter

Job Title Senior Supervisor

Address 6575 North W St.
Street

Pensacola FL 32505
City *State* *Zip*

Phone 850-471-6424

Email LLSalter@myescambia.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Escambia County EMS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/1/16
Meeting Date

SB 1442
Bill Number (if applicable)

Topic Out of Network Svcs

Amendment Barcode (if applicable)

Name Alison Dudley

Speaking on the strike all amendment

Job Title President

Address P.O. Box 428
Street

Phone 850/559-1139

Tallahassee, Fl. 32312
City *State* *Zip*

Email alisondudley@dudleyand associates.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Radiological Society

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

SB 1442
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Jeff Scott

Job Title _____

Address 1430 Piedmont Dr. E.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850 224-6496

Email jscott@flmedical.org

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-1-16
Meeting Date

SB 1442
Bill Number (if applicable)

Topic Out of Network Billing

Amendment Barcode (if applicable)

Name Diane Gowski, MD

Job Title MD / physician

Address 1383 Temple St
Street

Clearwater FL 33756
City *State* *Zip*

Phone 727-480-7574

Email dianetg@aol.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Florida Chapter of AAPS (Association of American Physicians & Surgeons)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/1/16
Meeting Date

1442
Bill Number (if applicable)

Topic Balance Billing

Amendment Barcode (if applicable)

Name Arlene Smith

Job Title Legislative Affairs

Address 700 Catalina Drive
Street
Dayton Beach, FL 32114
City *State* *Zip*

Phone 386-405-1552

Email asmith@volusia.org

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Volusia County

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1504
INTRODUCER:	Senator Bean
SUBJECT:	Credit for Relevant Military Service
DATE:	January 24, 2016
REVISED:	2/2/2016

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

I. Summary:

SB 1504 authorizes the Department of Health (DOH) to waive fees and issue licenses to active duty U.S. military personnel who are within 6 months of an honorable discharge; and issue temporary licenses to military spouses, in health care professions that do not require licenses in other states. The applicant must provide evidence of military training or experience substantially equivalent to that required in Florida, and obtain a passing score on a national standards organization exam, if one is required. The bill also eliminates the requirement for a military spouse who has been issued a temporary dental license to practice under the indirect supervision of a Florida dentist.

The bill requires the Construction Industry and Electrical Contractor's Licensing Boards and the Department of Agriculture and Consumer Services (DACS), to provide methods for honorably discharged veterans to satisfy the licensure requirements for a specific contractor's license or for licenses as private investigators, private security officers, and recovery agents, respectively, by receiving credit for their substantially similar military training and education. The boards and the DACS are to identify overlaps and gaps, between the licensure requirements and the veteran's military training and education in their respective areas of jurisdiction. They are to assist in identifying training programs to fill those gaps. The Department of Business and Professional Regulation (DBPR), in conjunction with the boards, and the DACS are to provide an annual report to the Senate President, Speaker of the House of Representatives, and the Governor detailing the results of the boards' efforts and recommendations for improvement and the DACS efforts and recommendations for improvement.

SB 1504 requires the Department of Highway Safety and Motor Vehicles, and the Department of Military Affairs, to create a commercial drivers' license testing pilot program to provide testing opportunities to qualified members of the North Florida National Guard.

II. Present Situation:

Health Care Practitioner Licensure

The DOH is responsible for the regulation of health practitioners and health care facilities in Florida for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA), working in conjunction with 22 boards and six councils, licenses and regulates seven types of health care facilities, and more than 200 license types, in over 40 health care professions.[1] Any person desiring to be a licensed health care professional in Florida must apply to the DOH, MQA in writing.[2] Most health care professions are regulated by a board or council in conjunction with the DOH and all professions have different requirements for initial licensure and licensure renewal.[3]

Military Health Care Practitioners

Section 456.024, F.S., provides that any member of the U.S. Armed Forces who has served on active duty in the military, reserves, National Guard, or in the United States Public Health Service, as a health care practitioner, is also eligible for licensure in Florida. The DOH is required to waive fees and issue these individuals a license if they submit a completed application and proof of the following:

- A honorable discharge within six months before or after, the date of submission of the application;[4]
- An active, unencumbered license issued by another state, the District of Columbia, or a U.S. possession or territory, with no disciplinary action taken against it in the five years preceding the date of submission of the application;
- An Affidavit that he or she is not, at the time of submission, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reasons related to the practice of the profession for which he or she is applying;
- Documentation of actively practicing his or her profession for the three years preceding the date of submission of the application; and
- A completed fingerprint card for a background screening, if required for the profession for which he or she is applying.[5]

Florida offers an expedited licensure process to facilitate veterans seeking licensure in a health care profession in Florida through its Veterans Application for Licensure Online Response System (VALOR).[6] In order to qualify, a veteran must apply for the license within six months

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[1] Florida Dep't of Health, Medical Quality Assurance, *Annual Report and Long Range Plan, 2014-2015*, p.6, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf
[2] Section 456.013, F.S.
[3] *See* chs. 401, 456-468, 478, 480, 483, 484, 486, 490, and 491, F.S.
[4] A form DD-214 or an NGB-22 is required as proof of honorable discharge. Department of Health, *Veterans*, http://www.floridahealth.gov/licensing-and-regulation/armed-forces/veterans/index.html (last visited Dec. 15, 2015).
[5] *Id*. The Military Veteran Fee Waiver Request Form, also must be submitted with the application for licensure to receive waiver of fees and is available on the DOH website.
[6] Florida Dep't of Health, *Veterans*, http://www.floridahealth.gov/licensing-and-regulation/armed-forces/veterans/index.html, (last visited Dec. 15, 2015).

before, or six months after, he or she is honorably discharged from the Armed Forces; and there is no application fee, licensure fee, or unlicensed activity fee.[7]

A board, or the department if there is no board, may also issue a temporary health care professional license to the spouse of an active duty member of the Armed Forces upon submission of an application form and fees. The applicant must hold a valid license for the profession issued by another state, the District of Columbia, or a possession or territory of the United States and may not be the subject of any disciplinary proceeding in any jurisdiction relating to the practice of a regulated health care profession in Florida. A spouse who is issued a temporary professional license to practice as a dentist under this authority must practice under the indirect supervision of a Florida dentist.

Construction and Electrical Contractors

The DBPR is the agency charged with licensing and regulating various businesses and professionals in the state. The Division of Professions is responsible for the licensing 415,000 professions including construction contractors,[8] electrical contractors and alarm system contractors. The Construction Industry Licensing Board licenses and regulates the construction industry and the Electrical Contractor's Licensing Board licenses and regulates alarm system and electrical contractors. Licenses for these professions may be either Certified or Registered Licenses. Certified licenses are statewide and allow the contractor to work anywhere in Florida. Registered licenses are limited to certain local jurisdictions and only allow a contractor to work in the cities or counties where the contractor holds a certificate of competency.[9]

Section 489.111(2)(c), F.S., provides the experience and education requirements for all construction contractor applicants, without exception for military veterans. These requirements include four years of experience in the category applied for, with one year as a supervisor. Applicants may apply up to three years of college credit toward the experience requirements. The Construction Industry Licensing Board reviews applicant experience when necessary to determine if the experience is within the category applied for.

Section 489.511(1)(b)3.c., F.S., provides that an applicant for an electrical or alarm system contractor license may use technical experience in electrical or alarm system work with the military or a governmental entity to meet the minimum six year experience requirement.

Section 489.511(1)(b)3.e., F.S., provides for technical education to be used in conjunction with experience to meet the six year experience requirements, and technical training received in the military is acceptable under this provision. The Electrical Contractors' Licensing Board reviews all applications to determine if the required training and experience has been met.

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[7] *Id.*

[8] Section 489.105, F.S., divides contractors into Division I and Division II contractors. Division I contractors include general, building, and residential contractors. Division II contractors include sheet metal, roofing, 3 classes of air conditioning, mechanical, commercial and residential pool, 3 types of pool, plumbing, underground excavating, solar, pollutant storage, and specialty contractors.

[9] Florida Dep't of Business and Professional Regulation, Construction Industry Licensing Board, *Definition of Occupation and Class Codes*, available at: http://www.myfloridalicense.com/DBPR/pro/cilb/codes.html, (last visited Jan. 21, 2016).

Ex-Military Construction and Electrical Contractors

Section 455.213, F.S., requires the DBPR to waive the initial licensing fee, the initial application fee, and the initial unlicensed activity fee for an honorably discharged military veteran, or his or her spouse at the time of discharge, if he or she applies for a license within five years after discharge.

Section 455.02, F.S., provides that any member of the military on active duty in the military, who at the time he or she became active was in good standing with any DBPR administrative board,[10] he or she will be kept in good standing, without registering, paying fees or dues, or performing any act required for continued licensure, as long as the service member remains on active duty and does not engage in his or her profession in the private sector for profit.

Section 455.02, F.S., also provides that the DBPR may issue a temporary license to the spouse of an active duty member of the military if the spouse provides the following:

- Application fee;
- Proof of his or her marriage to an active duty military member;
- Proof of a valid professional license in another state, the District of Columbia, any U.S. possession or territory, or any foreign jurisdiction;
- Proof of active duty military orders that the applicant and his or her spouse are both assigned to duty in Florida; and
- A complete set of the applicant's fingerprints to be submitted to the Department of Law Enforcement and the Federal Bureau of Investigation for state and federal criminal background check, at the applicant's expense.

The temporary license expires six months after the date of issuance and is not renewable.

Licensing of Private Investigators, Private Security Officers and Recovery Agents

Private investigators, private security officers, and recovery agents are regulated by the DACS under, ch. 493, F.S., and Rule 5N-1, Florida Administrative Code (F.A.C.), which sets out the requirements for a person or business to obtain and renew the various types of licenses. In 2015, the DACS, Division of Licensing, regulated 26 different licenses under ch. 493, F.S.: six private investigator, seven private security officer, seven recovery agent, and six firearm; for a total of 1,668,339 licensees in Florida.[11]

Section 493.6106, F.S., provides that applicants for licenses as a private investigator, security officer or recovery agent must:

- Be 18 years of age;
- A U.S. citizen, legal resident or have authority to work by the U.S. Citizenship and Immigration Services (USCIS);

[10] See s. 20,165(4)(a), F.S., for a complete list of a complete list of all boards and programs established within the Division of Professions.

[11] Florida DACS, Division of Licensing, *Number of Licensees by Type As of December 31, 2015*, available at http://www.freshfromflorida.com/content/download/7471/118627/Number_of_Licensees_By_Type.pdf, (last visited Jan. 22, 2016).

- Have no disqualifying criminal history;
- Be of good moral character; and
- Have no history of incompetency, mental illness, or history of use of illegal drugs or alcoholism, unless evidence is presented showing successful completion of a rehabilitation program, or current mental competency, as appropriate.

Those applicants must provide to the DACS, among other things, an application with the following:

- Name;
- Date of birth;
- Social Security number;[12]
- Place of Birth;
- A statement of all criminal convictions, including dispositions, and adjudications withheld;
- A statement of whether he or she has been adjudicated incapacitated or committed to a mental institution;
- A statement regarding any history of illegal drug use or alcohol abuse;
- One full-face, color photograph; and
- A full set of prints on the division's fingerprint card or submitted electronically via a personal inquiry waiver and the appropriate fees.[13]

The DACS currently requires returning veterans and their spouses to pay application fees, fingerprint fees, and all other applicable fees when applying for licenses under ch. 493, F.S., as private investigators, security officers or recovery agents.

Commercial Drivers' License Examination Process

The Florida Department of Highway Safety and Motor Vehicles (DHSMV) administers all driving tests. All applicants for a commercial driver license are required to have an Operator's License and pass the vision and hearing tests. Applicants must be at least 18 years of age. If they are under 21, they will be restricted to intrastate operation only. Oral exams may be given in English or Spanish with the exception of skills test or Hazmat exams. Interpreters may not be used.[14]

[12] The DACS will not disclose an applicant's social security number without consent of the applicant to anyone outside the DACS unless required by law. *See* Chapter 119, F. S., 15 U.S.C., ss. 1681 et seq., 15 U.S.C. ss. 6801 et seq., 18 U.S.C. ss. 2721 et seq., Pub. L. No. 107-56 (USA Patriot Act of 2001), and Presidential Executive Order 13224.

[13] *See also* Fla. Dept. of Agriculture and Consumer Affairs, *Private Investigator Handbook*, p. 11, available at https://licensing.freshfromflorida.com/forms/P-00093_PrivateInvestigatorHandbook.pdf; *Security Officer Handbook*, p. 16, *available at* https://licensing.freshfromflorida.com/forms/P-00092_SecurityOfficerHandbook.pdf; *Recovery Agent Handbook*, at p. 9, https://licensing.freshfromflorida.com/forms/P-00094_RecoveryAgentHandbook.pdf, (last visited Jan. 22, 2016).

[14] Florida Dep't of Highway Safety and Motor Vehicles, *How do I obtain my Commercial Driver License (CDL)?*, available at http://www.flhsmv.gov/ddl/cdl.html, (last visited Jan. 22, 2016).

There are three types of CDL licenses in Florida: Class A, Class B, and Class C. Which license is required is dependent upon the weight and type of the vehicle to be operated, and the materials being transported.[15]

Active duty military or veterans requesting to be issued a CDL due to qualifications of experience while serving on military duty must:

- Pass all required knowledge[16] and endorsement exams for the CDL license class and endorsements they are applying to obtain; and
- Present the Certification for Waiver of Skill Test for Military Personnel form completed by their commanding officer or designee while on active duty or within 90 days of separation from service.[17]

Military are only exempt from taking the skills exams. The process must be completed, and the CDL issued, within 120 days of separation from service. The Certification for Waiver of Skill Test form for Military Personnel can be provided to the candidate.[18]

The portion of the examination which tests an applicant's safe driving ability is to be administered by the DHSMV or by an entity authorized by the DHSMV to administer such examination, pursuant to s. 322.56, F.S. Such examination is to be administered at a location approved by the DHSMV. A person who seeks to retain a hazardous-materials endorsement must, upon renewal, pass the test for such endorsement as specified in s. 322.57(1)(e), F.S., if the person has not taken and passed the hazardous-materials test within two years preceding his or her application for a commercial driver license in this state.[19]

Effect of Proposed Changes:

Initial Licensure Requirements

Military Health Care Practitioners [20]

SB 1504 amends s. 456.024, F.S., to authorize the DOH to waive fees[21] and issue health care licenses to active duty U.S. military personnel who apply either six months before, or six months after, an honorable discharge, in professions that do not require licensure in other states,[22] if the applicant can provide evidence of training or experience equivalent to that required in Florida,

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[15] Florida Dep't of Highway Safety and Motor Vehicles, "*How do I obtain my Commercial Driver License (CDL)?" available at:* http://www.flhsmv.gov/ddl/cdl.html, (last visited Jan. 22, 2016).
[16] *See* s. 322.12(4), F.S.
[17] See supra note 15.
[18] *See* supra note 15.
[19] *See* supra note 16.
[20] See section 1 of the bill.
[21] Section 456.013(13), F.S., currently require the DOH to wave the *initial* licensing application and unlicensed activity fees for a military veteran and his or her spouse at the time of discharge if he or she applies to the DOH for an initial license within 60 days of the veteran's honorable discharge from any branch of the U.S. Armed Forces. The applicant must provide supporting documentation required by the DOH and use the DOH prescribed form.
[22] Professions not licensed in all states: Respiratory therapists (and assistants), Clinical Laboratory Personnel, Medical Physicists, Opticians, Athletics trainers, Electrologists, Nursing home administrators, Midwives, Orthotists (and assistants), Prosthetists (and assistants), Pedorthotists (and assistants), Orthotic fitters (and assistants), Certified chiropractic physician assistants, Pharmacy Technicians.

and proof of a passing score on a national standards organization exam, if one is required in Florida.

The DOH may also issue temporary licenses to active duty military spouses, in professions that do not require licensure in other states,[23] if the applicant can provide evidence of training or experience equivalent to that required in Florida, and proof of a passing score on a national standards organization exam, if one is required in Florida.[24]

The bill also eliminates the requirement that a military spouse who has been issued a temporary dental license practice under the indirect supervision of a Florida dentist.

Ex-Military Construction and Electrical Contractors

SB 1504 creates ss. 489.1131 and 489.5161, F.S., and requires the Construction Industry Licensing Board and Electrical Contractor's Licensing Board, to provide methods for honorably discharged veterans to satisfy the licensure requirements for a specific contractor's license by receiving credit to the fullest extent possible towards their licensing requirements for their substantially similar military training and education. The boards are to identify the overlaps, and the gaps, between the licensure requirements and the veteran's military training and education. They are to assist in identify training programs to fill those gaps.

Beginning October 1, 2017, the DBPR, in conjunction with the boards, is to provide an annual report titled, "Construction and Electrical Contracting Veteran Application Statistics", to the Senate President, Speaker of the House of Representatives, and the Governor detailing the following for both ss. 489.1131, and 489.5161, F.S.:

- The number of applicants who identified themselves as veterans;
- The number of veterans whose application for a license was approved;
- The number of veterans whose application for a license was denied, including the reasons for denial;
- Data on the application processing times for veterans;
- The boards' efforts to assist veterans in identifying programs that offer training and education needed to meet the requirements for licensure;
- The boards' identification of the most common overlaps and gaps between requirements for licensure and the military training and education received and completed by the veteran applicants; and
- Recommendations on ways to improve the DBPR's ability to meet the needs of veterans which would effectively address the challenges that veterans face when separating from military service and seeking a license regulated by the department pursuant to ch. 489, part I and part II, F.S.

Ex-Military Private Investigators, Private Security Officers and Recovery Agents

SB 1504 creates s. 493.61035, F.S., and requires the DACS to provide a method for honorably discharged veterans to satisfy the licensure requirements for licenses as private investigators, private security officers, and recovery agents by receiving credit to the fullest extent possible

[23] *Id.*
[24] *Supra* note 21.

toward the requirements for licensure for their substantially similar military training and education. The DACS is to identify the overlaps, and the gaps, between the license requirements and the veteran's military training and education. The DACS is to assist in identify training programs to fill the gaps.

Beginning October 1, 2017, the DACS is to provide an annual report to the Senate President, Speaker of the House of Representatives, and the Governor detailing the following for s. 493.61035, F.S.:

- The number of applicants who identified themselves as veterans;
- The number of veterans whose application for a license was approved;
- The number of veterans whose application for a license was denied, including the reasons for denial;
- Data on the application processing times for veterans;
- The DACS's efforts to assist veterans in identifying programs that offer training and education needed to meet the requirements for licensure;
- The DACS's identification of the most common overlaps and gaps between requirements for licensure and the military training and education received and completed by the veteran applicants; and
- Recommendations on ways to improve the DACS's ability to meet the needs of veterans which would effectively address the challenges that veterans face when separating from military service and seeking a license regulated by the department pursuant to ch. 493, F.S.

Commercial Drivers' License Testing Piolet Program for North Florida National Guard

SB 1504 requires the Department of Highway Safety and Motor Vehicles (DHSMV) and the Department of Military Affairs, beginning July 1, 2017, to jointly conduct a pilot program to provide onsite commercial driver license testing opportunities to qualified members of the Florida National Guard pursuant to the DHSMV commercial driver license skills test waiver under s. 322.12, F.S, described previously.[25] Testing must be held at a Florida National Guard Armory, an Armed Forces Reserve Center, or the Camp Blanding Joint Training Center. The pilot program shall be accomplished using existing funds appropriated to the departments.

The DHSMV and the Department of Military Affairs shall submit, by June 30, 2018, a report on the pilot program to the President of the Senate and the Speaker of the House of Representatives.

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

III. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[25] *See* supra note 15.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

IV. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may increase the number of veterans and their spouses receiving health care licenses; and increase the number of veterans receiving contractor, private investigator, private security, and recovery agent licenses.

C. Government Sector Impact:

Rulemaking would be required by the DOH, DBPR and DACS to develop veteran specific application processes and define what military education and training is substantially similar to current license requirements. Tracking mechanisms would need to be put in place for veterans' applications, approvals, denials, and the reasons for the denials. There would also be costs associated with preparing the annual reports required by the DBPR, and DACS. There will be no additional costs to the DHSMV and the Department of Military Affairs as their funding is to come from existing funds.

V. Technical Deficiencies:

None.

VI. Related Issues:

Not all professions have national standards examinations. An amendment may be advisable to recognize that some professions use regional standards examinations.

VII. Statutes Affected:

This bill substantially amends section 456.024 of the Florida Statutes,

This bill creates the following sections of the Florida Statutes: 489.1131, 489.5161, and 493.61035, F.S.

This bill creates an undesignated section of Florida law.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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

By Senator Bean

4-01387-16 20161504__

A bill to be entitled

An act relating to credit for relevant military service; amending s. 456.024, F.S.; providing for the issuance of a license to practice under certain conditions to a military health care practitioner in a profession for which licensure in a state or jurisdiction is not required to practice in the military; providing for the issuance of a temporary professional license under certain conditions to the spouse of an active duty member of the Armed Forces of the United States who is a health care practitioner in a profession for which licensure in a state or jurisdiction may not be required; deleting the requirement that an applicant who is issued a temporary professional license to practice as a dentist must practice under the indirect supervision of a licensed dentist; creating s. 489.1131, F.S.; requiring the Construction Industry Licensing Board to provide a method by which honorably discharged veterans may apply for licensure; providing for extension of credit toward licensing requirements for substantially similar military training and education; requiring identification and notification of overlaps and gaps between license requirements and the military training and education received by the applicant; requiring the Department of Business and Professional Regulation to provide an annual report to the Governor and Legislature; providing requirements for the annual report; creating s. 489.5161, F.S.; requiring the Electrical Contractors' Licensing Board to provide a method by which honorably discharged veterans may apply for licensure; providing for extension of credit

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4-01387-16 20161504__

toward licensing requirements for substantially similar military training and education; requiring identification and notification of overlaps and gaps between license requirements and the military training and education received by the applicant; requiring the Department of Business and Professional Regulation to annually report to the Governor and Legislature; providing requirements for the annual report; creating s. 493.61035, F.S.; requiring the Department of Agriculture and Consumer Services to adopt rules providing a method by which honorably discharged veterans may apply for licensure pursuant to ch. 493, F.S.; providing for extension of credit toward licensing requirements for substantially similar military training and education; requiring identification and notification of overlaps and gaps between license requirements and the military training and education received by the applicant; requiring an annual report to the Governor and Legislature; providing requirements for the annual report; requiring the Department of Highway Safety and Motor Vehicles and the Department of Military Affairs to create a commercial driver license testing pilot program; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) and paragraphs (a) and (j) of subsection (4) of section 456.024, Florida

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

Statutes, are amended to read:

456.024 Members of Armed Forces in good standing with administrative boards or the department; spouses; licensure.—

(3) A person who serves or has served as a health care practitioner in the United States Armed Forces, United States Reserve Forces, or the National Guard or a person who serves or has served on active duty with the United States Armed Forces as a health care practitioner in the United States Public Health Service is eligible for licensure in this state. The department shall develop an application form, and each board, or the department if there is no board, shall waive the application fee, licensure fee, and unlicensed activity fee for such applicants. For purposes of this subsection, "health care practitioner" means a health care practitioner as defined in s. 456.001 and a person licensed under part III of chapter 401 or part IV of chapter 468.

(a) The board, or department if there is no board, shall issue a license to practice in this state to a person who:

1. Submits a complete application.

2. Receives an honorable discharge within 6 months before, or will receive an honorable discharge within 6 months after, the date of submission of the application.

3. Holds an active, unencumbered license issued by another state, the District of Columbia, or a possession or territory of the United States and who has not had disciplinary action taken against him or her in the 5 years preceding the date of submission of the application or is a military health care practitioner in a profession for which licensure in a state or jurisdiction is not required to practice in the military, who

provides evidence of military training or experience substantially equivalent to the requirements for licensure in this state in that profession, and who obtained a passing score on the appropriate examination of a national standards organization when required for licensure in this state.

4. Attests that he or she is not, at the time of submission, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reasons related to the practice of the profession for which he or she is applying.

5. Actively practiced the profession for which he or she is applying for the 3 years preceding the date of submission of the application.

6. Submits a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

The department shall verify information submitted by the applicant under this subsection using the National Practitioner Data Bank.

(4)(a) The board, or the department if there is no board, may issue a temporary professional license to the spouse of an active duty member of the Armed Forces of the United States who submits to the department:

1. A completed application upon a form prepared and furnished by the department in accordance with the board's rules;

2. The required application fee;

3. Proof that the applicant is married to a member of the

Armed Forces of the United States who is on active duty;

4. Proof that the applicant holds a valid license for the profession issued by another state, the District of Columbia, or a possession or territory of the United States~~,~~ and is not the subject of any disciplinary proceeding in any jurisdiction in which the applicant holds a license to practice a profession regulated by this chapter or is a health care practitioner in a profession for which licensure in a state or jurisdiction may or may not be required, who provides evidence of training or experience substantially equivalent to the requirements for licensure in this state in that profession, and who obtained a passing score on the appropriate examination of a national standards organization when required for licensure in this state; and

5. Proof that the applicant's spouse is assigned to a duty station in this state pursuant to the member's official active duty military orders~~; and~~

~~6. Proof that the applicant would otherwise be entitled to full licensure under the appropriate practice act, and is eligible to take the respective licensure examination as required in Florida~~.

~~(j) An applicant who is issued a temporary professional license to practice as a dentist pursuant to this section must practice under the indirect supervision, as defined in s. 466.003, of a dentist licensed pursuant to chapter 466.~~

Section 2. Section 489.1131, Florida Statutes, is created to read:

489.1131 Credit for relevant military training and education.-

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

(1) The board shall provide a method by which honorably discharged veterans may apply for licensure. The method must include:

(a) Extension of credit to the fullest extent possible toward the requirements for licensure for military training or education received and completed during service in the Armed Forces of the United States if the training or education is substantially similar to the training or education required for licensure.

(b) Identification of overlaps and gaps between the requirements for licensure and the military training and education received and completed by the veteran applicants and subsequent notification to the applicant of the overlaps and gaps.

(c) Assistance in identifying programs that offer training and education needed to meet requirements for licensure.

(2) Notwithstanding any other provision of law, beginning October 1, 2017, and annually thereafter, in conjunction with the board, the department is directed to prepare and submit a report titled "Construction and Electrical Contracting Veteran Applicant Statistics" to the President of the Senate, the Speaker of the House of Representatives, and the Governor. The report must include statistics and information relating to this section and s. 489.5161 which detail:

(a) The number of applicants who identified themselves as veterans;

(b) The number of veterans whose application for a license was approved;

(c) The number of veterans whose application for a license

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was denied, including the reasons for denial;

(d) Data on the application processing times for veterans;

(e) The boards' efforts to assist veterans in identifying programs that offer training and education needed to meet the requirements for licensure;

(f) The boards' identification of the most common overlaps and gaps between requirements for licensure and the military training and education received and completed by the veteran applicants; and

(g) Recommendations on ways to improve the department's ability to meet the needs of veterans which would effectively address the challenges that veterans face when separating from military service and seeking a license regulated by the department pursuant to chapter 489, part I.

Section 3. Section 489.5161, Florida Statutes, is created to read:

489.5161 Credit for relevant military training and education.-

(1) Each board shall provide a method by which honorably discharged veterans may apply for licensure. The method shall include:

(a) Extension of credit to the fullest extent possible toward the requirements for licensure for military training or education received and completed during service in the Armed Forces of the United States if the training or education is substantially similar to the training or education required for licensure.

(b) Identification of overlaps and gaps between the requirements for licensure and the military training and

education received and completed by veteran applicants and subsequent notification to the applicant of the overlaps and gaps.

(c) Assistance in identifying programs that offer training and education needed to meet requirements for licensure.

(2) Notwithstanding any other provision of law, beginning October 1, 2017, and annually thereafter, in conjunction with the board, the department is directed to prepare and submit a report titled "Construction and Electrical Contracting Veteran Applicant Statistics" to the President of the Senate, the Speaker of the House of Representatives, and the Governor. The report shall include statistics and information relating to this section and s. 489.1131 detailing:

(a) The number of applicants who identified themselves as veterans;

(b) The number of veterans whose application for a license was approved;

(c) The number of veterans whose applications for a license were denied, including data on the reasons for denial;

(d) Data on the application processing times for veterans;

(e) The boards' efforts to assist veterans in identifying programs that offer training and education needed to meet the requirements for licensure;

(f) The boards' identification of the most common overlaps and gaps between the requirements for licensure and the military training and education received and completed by the veteran applicants; and

(g) Recommendations on ways to improve the department's ability to meet the needs of veterans which would effectively

address the challenges that veterans face when separating from military service and seeking a license regulated by the department pursuant to chapter 489, part II.

Section 4. Section 493.61035, Florida Statutes, is created to read:

493.61035 Credit for relevant military training and education.—

(1) The department shall provide a method by which honorably discharged veterans may apply for licensure. The method must include:

(a) Extension of credit to the fullest extent possible toward the requirements for licensure for military training or education received and completed during service in the Armed Forces of the United States if the training or education is substantially similar to the training or education required for licensure.

(b) Identification of overlaps and gaps between the requirements for licensure and the military training and education received and completed by the veteran applicants and subsequent notification to the applicant of the overlaps and gaps.

(c) Assistance in identifying programs that offer training and education needed to meet requirements for licensure.

(2) Notwithstanding any other provision of law, beginning October 1, 2017, and annually thereafter, the department is directed to prepare and submit a report to the President of the Senate, the Speaker of the House of Representatives, and the Governor. In addition to any other information the Legislature may require, the report must include statistics and relevant

information that detail:

(a) The number of applicants who identified themselves as veterans;

(b) The number of veterans whose application for a license was approved;

(c) The number of veterans whose application for a license was denied, including the reasons for denial;

(d) Data on the application processing times for veterans;

(e) The department's efforts to assist veterans in identifying programs that offer training and education needed to meet the requirements for licensure;

(f) The department's identification of the most common overlaps and gaps between the requirements for licensure and the military training and education received and completed by the veteran applicants; and

(g) Recommendations on ways to improve the department's ability to meet the needs of veterans which would effectively address the challenges that veterans face when separating from military service and seeking a license for a profession or occupation regulated by the department pursuant to chapter 493.

Section 5. National Guard commercial motor vehicle driver license testing pilot program.—

(1) Beginning July 1, 2017, the Department of Highway Safety and Motor Vehicles and the Department of Military Affairs shall jointly conduct a pilot program to provide onsite commercial driver license testing opportunities to qualified members of the Florida National Guard pursuant to the Department of Highway Safety and Motor Vehicles commercial driver license skills test waiver under s. 322.12, Florida Statutes. Testing

must be held at a Florida National Guard Armory, an Armed Forces Reserve Center, or the Camp Blanding Joint Training Center. The pilot program shall be accomplished using existing funds appropriated to the departments.

(2) By June 30, 2018, the Department of Highway Safety and Motor Vehicles and the Department of Military Affairs shall jointly submit a report on the pilot program to the President of the Senate and the Speaker of the House of Representatives.

Section 6. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.

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CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 2/1/2016 1:33:59 PM
Ends: 2/1/2016 3:30:50 PM Length: 01:56:52

1:33:58 PM Meeting Called to order
1:34:32 PM Chair Bean Introduction
1:34:37 PM Roll Call
1:34:44 PM Quorum Present
1:34:54 PM Tab 5 Sen. Brandes
1:35:24 PM Sen Brandes explains
1:35:51 PM Call for Questions
1:35:59 PM BC 802432
1:36:11 PM Sen Brandes explains
1:36:29 PM BC 802432 adopted
1:38:12 PM Dr. Ken Brummel Smith speaks to inform
1:39:54 PM Dr. Diane Gowski speaks in opposition
1:44:47 PM Attorney Teresa Ward , Florida Right to Life, speaks in opposition
1:45:47 PM Sen Joyner question
1:46:27 PM Atty Ward responds
1:46:39 PM Sen Joyner question
1:46:46 PM Atty Ward responds
1:46:57 PM Sen Joyner question
1:47:12 PM Atty Ward responds
1:47:52 PM Michael Sheedy speaks to inform
1:48:23 PM Atty Martha Edenfield waves in opposition
1:48:46 PM Sen Joyner question
1:49:20 PM Sen Brandes responds
1:50:58 PM Sen Joyner question
1:51:59 PM Sen Brandes responds
1:52:59 PM Sen Joyner follow up question
1:53:08 PM Sen Bandes responds
1:53:14 PM Sen Garcia comment
1:53:50 PM Sen Joyner comment
1:55:34 PM Sen Brandes closes
1:56:35 PM CS SB 664 passes favorably
1:57:14 PM Tab 4 SB 662 Sen Brandes
1:57:42 PM Sen Brandes explains A 23508
1:58:13 PM Sen Joyner question
1:58:54 PM CS SB 662 passes favorably
1:59:26 PM Tab 1 Sen Grimsley SB 132
1:59:54 PM Sen Grimsley explains
2:00:20 PM A BC 762054
2:00:50 PM Sen Garcia explains
2:00:59 PM Paul Lambert, Fl Chiropractic Assoc., waives in support
2:01:11 PM BC 762054 adopted
2:01:29 PM Jeff Scott, Fl Medical Assoc., waives in support
2:01:38 PM Chris Nuland waives in support
2:01:46 PM Steve Wynn, Fl Osteopathic, waives in support
2:01:58 PM Tim Nungesser, NFIB, speaks in support
2:02:50 PM Melissa Fause , Americans for Prosperity, waives in support
2:02:59 PM Catherine Baer, The Tea Party Network, waves in support
2:03:08 PM Dr. Diane Gowski, AAPS, speaks in support
2:04:59 PM CS SB 132 roll call
2:05:44 PM CS SB 132 passes favorably
2:05:48 PM Tab 7 SB 1082
2:06:10 PM Liz Mabry, Legislative Aid, explains

2:07:01 PM Robert Watson , FSU professor, waives in support
2:07:25 PM Presenters waive in support: Stefano Leitner,Alisa Lapolt , Robert Watson, Linda Smith, Penelope P. Ziegler
2:08:17 PM SB 1082 passes favorbly
2:08:51 PM Tab 10 SB 1378
2:09:14 PM Sen Garcia explains
2:10:15 PM Sen Garcia further explains
2:12:55 PM Mr.David Siegel, father of prescription drug victim, shares his story and speaks in favor
2:13:57 PM Jackie Siegal speaks in favor
2:14:18 PM A agreed to be name bill Victoria 's Law
2:14:57 PM Melissa Ramba waives in opposition
2:15:36 PM Atty Steve Geller waives in support
2:15:43 PM Sen Garcia comments
2:16:51 PM SB 1378, Victoria's Law, passes favorably
2:17:25 PM Tab 6 SB 964
2:17:42 PM Sen Grimsley explains
2:18:14 PM Sen Joyner question
2:19:04 PM Sen Grimsley responds
2:19:39 PM Sen Joyner comment
2:20:06 PM A BC 623746
2:20:18 PM Sen Grimsley explains
2:20:49 PM A 623746 adopted
2:21:00 PM Linda Smith waives in support
2:21:12 PM Stefano Leitner, Professional resource Network, waive in support
2:21:19 PM Melody Arnold, Florida Health Care, waives in support
2:21:34 PM SB 964 passes favorably
2:22:26 PM Tab 12 SB 1504 Sen Bean
2:22:35 PM Sen Bean explains
2:24:01 PM SB 1504 passes favorably
2:25:20 PM Tab 8 SB 1084 Sen Gaetz
2:25:42 PM Sen Gaetz explains
2:27:15 PM Sen Braynon question
2:28:16 PM Jack McRay, AARP, waives in support
2:28:23 PM Mike Fischer, American Cancer Society, waives in support
2:28:47 PM Steve Wynn waives n support
2:29:09 PM John Langden, American College of Physicians of Fl, speaks in support
2:31:11 PM Dr. Robert Levi waives in support
2:31:50 PM Pam Langford , Heals of the South, speaks in support
2:33:11 PM Brittney Hunt, Florida Chamber of Commerce speaks in opposition
2:34:13 PM Audrey Brown, waives in opposition
2:34:21 PM Brewster waives in opposition
2:34:33 PM Rich Robleto waives in support
2:34:47 PM Douglas Murray waives in support
2:35:04 PM Discussion
2:35:08 PM Sen Joyner comment-close
2:35:11 PM Sen Gaetz comment
2:35:39 PM SB 1084 passes favorably
2:35:52 PM Tab 3 SB 620 Sen Grimsley
2:36:01 PM Sen Grimsley explains
2:37:04 PM Call for question
2:37:16 PM Public Testimony
2:37:21 PM James Wylie, Fl Funeral Cemetery, waive in support
2:37:29 PM Jerry Wylie waive in support
2:37:41 PM Jeff Scott waives in supprt
2:37:49 PM Jack McRay, AARP, waives in support
2:37:57 PM Georgia McKeown, Fl Cemetary & Funeral Assoc., waives in support
2:38:22 PM Richard Pinsky, Miami, waives in opposition
2:38:47 PM Jess McCarty , Miami Dade, speaks in opposition
2:39:29 PM Vice Chair Sobel question
2:40:33 PM Sen Grimsley waives close
2:40:41 PM SB 620 passes favorably
2:41:00 PM Tab 9 SB 1144 Pres. Gaetz

2:41:13 PM Sen Gaetz explains
2:43:38 PM Sen Joyner question
2:44:00 PM Pres. Gaetz responds
2:44:34 PM Sen Joyner follow up question
2:45:00 PM Pres Gaetz responds
2:45:26 PM Sen Joyner follow up question
2:45:41 PM Sen Gaetz responds
2:47:26 PM Sen Joyner follow up question
2:48:34 PM Sen Gaetz responds
2:49:04 PM Sen Joyner follow up question
2:49:37 PM Sen Gaetz responds
2:49:47 PM Vice Chair Sobel question
2:51:12 PM Sen Gaetz responds
2:51:51 PM Vice Chair Sobel follow up question
2:52:43 PM Sen Gaetz responds
2:52:49 PM Vice Chair follow up question
2:53:01 PM Sen Gaetz responds
2:53:32 PM Vice Chair Sobel follow up question
2:54:29 PM Sen Gaetz responds
2:54:59 PM Sen Joyner question
2:55:30 PM Sen Gaetz responds
2:55:34 PM Sen Joyner follow up question
2:56:24 PM Sen Gaetz responds
2:59:26 PM Sen Joyner follow up question
3:00:29 PM Sen Gaetz responds
3:02:23 PM Sen Joyner follow up question
3:03:40 PM Sen Gaetz responds
3:04:00 PM Vice Chair Sobel question
3:04:16 PM Sen Gaetz responds
3:04:22 PM Vice Chair Sobel follow up question and comment
3:04:49 PM Sen Gaetz responds
3:05:37 PM Mark Delegal, Safety Net Hospital Alliance, speaks in opposition
3:07:14 PM Bill Bell, General Counsel Fl Hospital Assoc., speaks in opposition
3:08:58 PM Paul Ledford, Fl Hospice, waives in opposition
3:09:33 PM Bob Asztalos , Fl Health Care Assoc., waives in opposition
3:10:09 PM Sen Joyner comments
3:11:03 PM Vice Chair Sobel comments
3:12:51 PM Sen Grimsley comments
3:14:12 PM Sen Gaetz closes on SB 1144
3:17:33 PM Roll Call on SB 1144
3:18:07 PM SB 1144 passes favorably
3:18:14 PM SB 526 TP
3:18:19 PM Tab 11 SB 1442
3:18:29 PM Sen Garcia explains
3:19:57 PM A 976950 adopted
3:20:57 PM Sen Joyner question
3:21:31 PM Sen Garcia responds
3:22:04 PM Sen Joyner follow up question
3:22:14 PM Ron Watson waives in support
3:22:23 PM Pat Coston, EMS, waives in opposition
3:22:32 PM Stephen Ecenia, HCA, waive in support
3:22:40 PM Carrie Roth, Fl Ambulance Assoc., waives in opposition
3:22:59 PM Audrey Brown waive in support
3:23:21 PM Alison Dudley, Fl Radiological Society, speaks in opposition
3:24:24 PM Rich Robelto, OIR, waives in support
3:24:28 PM Joe Scialdone, Fl Ambulance Assoc., speaks in opposition
3:26:27 PM Sen Braynon motion for time cert at 3:29
3:26:56 PM Jeff Scott, Fl Medical Association, waives in opposition
3:27:05 PM Sha 'ron James, Office of Insurance, is in favor of bill
3:27:06 PM Motion approved for time cert
3:27:15 PM Tim Nungesser,NFIB, waives in favor
3:27:19 PM Bill Bell, Fl Hospital Assoc., speaks to inform

3:27:30 PM Daniel Brennan, Fl College of Emergency Physicians
3:28:03 PM Arlene Smith, Legislative Affairs Volusia County, waives in opposition
3:28:09 PM Dr. Diane Gowski waives in opposition
3:28:18 PM Arlene Smith, EMS, waives in opposition
3:28:32 PM Vice Chair Sobel comments
3:29:01 PM Sen Flores recommend bill as CS
3:29:26 PM SB 1442 Roll Call
3:29:58 PM SB 1442 passes favorably
3:30:17 PM Meeting adjourned