CS/SB 544 by **HR, Sobel**; (Similar to H 0477) Health Care

CS/SB 316 by **CF, Wise**; (Identical to H 1035) Alzheimer's Disease

CS/SB 450 by **HR, Oelrich**; (Similar to H 0241) Emergency Medical Services

CS/SB 470 by **HR, Jones**; (Similar to CS/H 0413) Chiropractic Medicine

547226	A	S	RCS	BHA, Garcia	Delete L.255 - 362.	01/26 10:37 AM

CS/SB 414 by **HR, Negron**; (Similar to CS/H 0171) Osteopathic Physicians

CS/SB 730 by **HR, Flores (CO-INTRODUCERS) Negron, Gaetz**; (Similar to H 0727) Medicaid Managed Care Plans

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Tuesday, January 24, 2012
TIME: 1:00 —2:00 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 544** Health Regulation / Sobel (Similar H 477)	Health Care; Requiring that any physician or osteopathic physician who performs certain medical procedures in an office setting to register the office with the Department of Health unless that office is licensed as a facility under ch. 395, F.S., relating to hospital licensing and regulation, etc. HR 12/07/2011 Fav/CS BHA 01/19/2012 Not Considered BHA 01/24/2012 Favorable BC	Favorable Yeas 7 Nays 0
2	**CS/SB 316** Children, Families, and Elder Affairs / Wise (Identical H 1035)	Alzheimer's Disease; Directing the Department of Elderly Affairs to develop and implement a public education program relating to screening for Alzheimer's disease; providing criteria for awarding grants; creating the memory-impairment screening grant program; requiring grant recipients to submit an evaluation of certain activities to the department; authorizing the department to provide technical support; providing for implementation of the public education program to operate within existing resources of the department; providing that implementation of the memory-impairment screening grant program is contingent upon an appropriation of state funds or the availability of private resources; specifying the types of facilities where an employee or direct caregiver providing care for persons with Alzheimer's disease may begin employment without repeating certain training requirements, etc. CF 11/03/2011 Fav/CS BHA 01/24/2012 Favorable BC	Favorable Yeas 7 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**CS/SB 450** Health Regulation / Oelrich (Similar H 241, Compare S 1400)	Emergency Medical Services; Deleting the requirement for emergency medical technicians, paramedics, and 911 public safety telecommunicators to complete an educational course on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome; redefining the term "basic life support" for purposes of the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act; revising the requirements for certification or recertification as an emergency medical technician or paramedic; revising requirements for an institution that conducts an approved program for the education of emergency medical technicians and paramedics, etc. HR 12/07/2011 Fav/CS CA 01/12/2012 Favorable BHA 01/24/2012 Favorable BC	Favorable Yeas 7 Nays 0
4	**CS/SB 470** Health Regulation / Jones (Similar CS/H 413)	Chiropractic Medicine; Revising the requirements for obtaining a chiropractic medicine faculty certificate; authorizing the Board of Chiropractic Medicine to approve continuing education courses sponsored by chiropractic colleges under certain circumstances; revising requirements for a person who desires to be licensed as a chiropractic physician; requiring that a chiropractic physician preserve the identity of funds or property of a patient in excess of a specified amount; providing that services rendered by a certified chiropractic physician's assistant under indirect supervision may occur only at the supervising chiropractic physician's address of record; authorizing a registered chiropractic assistant to operate therapeutic office equipment, etc. HR 12/07/2011 Fav/CS BHA 01/24/2012 Fav/CS BC	Fav/CS Yeas 6 Nays 1
5	**CS/SB 414** Health Regulation / Negron (Similar CS/H 171)	Osteopathic Physicians; Revising the requirements for licensure or certification as an osteopathic physician in this state; revising provisions relating to registration of physicians, interns, and fellows, etc. HR 12/07/2011 Fav/CS BHA 01/24/2012 Not Considered BC	Not Considered

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
6	**CS/SB 730** Health Regulation / Flores (Similar H 727)	Medicaid Managed Care Plans; Requiring the Agency for Health Care Administration to establish per-member, per-month payments; substituting the Medicare Advantage Coordinated Care Plan for the Medicare Advantage Special Needs Plan; revising the definition of "eligible plan" to include certain Medicare plans; limiting the penalty that a plan must pay if it leaves a region before the end of the contract term; providing that certain Medicare plans are not subject to procurement requirements or plan limits; requiring dually eligible Medicaid recipients to be enrolled in the Medicare plan in which they are already enrolled; revising the list of Medicare plans that are not subject to procurement requirements for long-term care plans; revising the list of Medicare plans in which dually eligible Medicaid recipients are enrolled in order to receive long-term care, etc. HR 01/19/2012 Fav/CS BHA 01/24/2012 Favorable BC	Favorable Yeas 7 Nays 0
7	Review and Discussion of Fiscal Year 2012-2013 Budget Issues Relating to: Agency for Health Care Administration Agency for Persons with Disabilities Department of Children and Family Services Department of Elder Affairs Department of Health Department of Veterans' Affairs		Discussed
	Public Testimony		Discussed
	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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 544
INTRODUCER:	Health Regulation and Senator Sobel
SUBJECT:	Health Care
DATE:	January 11, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davlantes	Stovall	HR	**Fav/CS**
2.	Bradford	Hendon	BHA	**Favorable**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill provides that any physician who performs liposuction procedures in which more than 1,000 cubic centimeters (cc) of fat is removed must register his or her office with the Department of Health (the department), unless the office is licensed as a facility under ch. 395, F.S., (hospitals, ambulatory surgical centers, and mobile surgical facilities). Identical changes are made to the statutes concerning allopathic and osteopathic physicians.

The bill would increase costs for physicians performing certain liposuction procedures who will be subject to a registration fee of $150 and either a $1500 annual fee for inspections or another fee to become accredited.

According to the Department of Health, there is a minimal fiscal impact to the state for increases in workload relating to registration and inspection of additional office surgery facilities which would be offset by the registration and inspection fees. Other non-recurring costs for rulemaking, updating the licensure database, and processing additional non-compliance complaints, can be absorbed with existing resources.

The bill will take effect on January 3, 2013.

This bill substantially amends ss. 458.309 and 459.005, F.S.

II. Present Situation:

Definitions

According to rules[1] adopted for the practice of medicine and osteopathic medicine, surgery is defined as any operative procedure, including the use of lasers, performed upon the body of a living human being for the purposes of preserving health, diagnosing or curing disease, repairing injury, correcting deformity or defects, prolonging life, relieving suffering, or any elective procedure for aesthetic, reconstructive, or cosmetic purposes, to include, but not be limited to: incision or curettage of tissue or an organ; suture or other repair of tissue or organ, including a closed as well as an open reduction of a fracture; extraction of tissue including premature extraction of the products of conception from the uterus; insertion of natural or artificial implants; or an endoscopic procedure with use of local or general anesthetic. Only licensed physicians are allowed to perform surgery under these rules.

Office surgery is defined as surgery which is performed outside any facility licensed under ch. 390, F.S., relating to abortion clinics, or ch. 395, F.S., relating to hospitals, ambulatory surgical centers, and mobile surgical facilities. Office surgical procedures may not be of a type that generally result in blood loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin; require major or prolonged intracranial, intrathoracic, abdominal, or major joint replacement procedures, except for laparoscopic procedures; directly involve major blood vessels; or are generally emergent or life threatening in nature.[2]

Levels of Office Surgery

Surgical procedures are divided by rule into three different levels based on the invasiveness of the procedure and the level of anesthesia required.[3] Each level of surgery has its own equipment and personnel requirements. However, nothing in these designations relieves the surgeon of the responsibility for making the medical determination that the office is an appropriate forum for the particular procedures to be performed on the particular patient. Each patient's medical history and comorbid health problems must be considered individually to maximize patient safety and reduce operative complications.

Level I office surgery consists of minor procedures in which the chances of complications requiring hospitalization are remote. Such procedures include excisions or repairs of lacerations limited to the skin or subcutaneous tissue, liposuction involving removal of less than 4000 cc of fat, various endoscopic imaging procedures, closed reduction of simple fractures or dislocations, and needle drainage of certain body fluids. Only local or topical anesthesia and minimal pre-operative tranquilization of the patient is permitted. Surgeons performing Level 1 office surgeries are required to complete continuing medical education courses concerning regional anesthesia and are recommended to be certified in basic life support (BLS). No surgical

[1] Rule 64B8-9.009, F.A.C., relates to allopathic physicians and is materially similar to Rule 64B15-14.007, F.A.C., which concerns osteopathic physicians.
[2] Rule 64B8-9.009(1), F.A.C. Identical provisions are found in Rule 64B15-14.007(1), F.A.C.
[3] Rule 64B8-9.009(3)-(6), F.A.C. Similar provisions are found in Rule 64B15-14.007(3)-(6), F.A.C.

assistants are necessary, and specific lifesaving equipment and medications are required to be on hand during the procedure.

Level II office surgery encompasses more invasive procedures which require peri-operative sedation and monitoring. Such procedures include hemorrhoid removal, hernia repair, breast biopsies, colonoscopies, and liposuction involving the removal of up to 4,000 cc of fat.[4] The level of sedation allowed under Level II office surgery is such that the patient remains able to maintain adequate cardiorespiratory function and to respond purposefully to verbal commands or tactile stimulation. Surgeons performing Level II office surgeries must be able to document satisfactory background, training, and experience to perform procedures under sedation and must also be trained in advanced cardiac life support (ACLS). The surgeon must be assisted by a qualified anesthesia provider[5] and at least one assistant[6] who is BLS-certified. An ACLS-certified physician, nurse, or physician assistant must be available to monitor the patient during his or her recovery from anesthesia. Specific lifesaving medications and equipment are also required to be on hand during the procedure and recovery.

Level IIA office surgeries are those Level II office surgeries with a maximum planned duration of 5 minutes or less and in which the chances of complications requiring hospitalization are remote. The same standards apply as for Level II procedures except that the assistance of a qualified anesthesia provider is not required.

Level III office surgery involves procedures which require general anesthesia. Only patients designated as Class I or II under the American Society of Anesthesiologists' (ASA) risk criteria are appropriate candidates for office surgery.[7] Specific pre-operative diagnostic tests and medical clearance must be obtained on ASA Class II patients older than 40. Surgeons and their assistants must demonstrate the same training, experience, and certification requirements as for Level II office surgeries, and surgeons must also have knowledge of the principles of general anesthesia. A qualified anesthesia provider is required to administer anesthesia, and a registered nurse, licensed practical nurse, physician assistant, or operating room technician must assist with the surgery. The surgical team must be familiar with emergency protocols for serious anesthesia complications, and specific lifesaving medications and equipment must be immediately available for use on the patient at all times. The same personnel needed for Level II office surgeries must be present to monitor the patient during recovery from anesthesia.

Rules and Regulations Governing Office Surgery

Subsection 458.309(3), F.S., relating to allopathic physicians, and s. 459.005(2), F.S., relating to osteopathic physicians, require that all physicians who perform Level II procedures lasting more

[4] Liposuction involving the removal of up to 4000 cc of fat can be classified as a Level I or Level II office surgery procedure depending on the level of anesthesia used.

[5] Qualified anesthesia providers include anesthesiologists, certified registered nurse assistants, registered nurses, or physician assistants qualified under Rule 64B8-30.012(2)(b)6. or 64B15-6.010(2)(b)6., F.A.C. An anesthesia provider may not function in any other capacity during the procedure.

[6] Additional assistance may only be provided by a physician, osteopathic physician, registered nurse, licensed practical nurse, or operating room technician.

[7] ASA Class I includes normal, healthy patients without any significant medical conditions. ASA Class II includes patients with a well-controlled disease of one body system and pregnant patients. ASA Classes III-VI encompass patients in increasingly severe stages of debilitation by a medical disease. (Source: ASA Physical Status Classification System, http://www.asahq.org/clinical/physicalstatus.htm, last visited on November 8, 2011).

than 5 minutes and all Level III surgical procedures in an office setting must register the office with the department unless that office is licensed as a facility pursuant to ch. 395, F.S. The language, which is identical in both statutes, also provides for annual inspection of such offices.

In addition to submitting a registration application, each physician who performs specified Level II and Level III surgeries in an office setting must pay the department a one-time registration fee of $150 and an annual inspection fee of $1,500 for each practice location.[8] The inspection and inspection fee may be waived for offices which undergo inspections as part of the accreditation process for the American Association for Accreditation of Ambulatory Surgery Facilities, the Accreditation Association for Ambulatory Health Care, or the Joint Commission on Accreditation of Healthcare Organizations.[9]

Each surgeon must maintain a log of all Level II and Level III surgical procedures performed, which must include certain essential data about the patient and the procedure. A policy and procedures manual as well as a risk management program must be designed, implemented, and updated annually for each surgery office. Any adverse incidents that occur within the office surgical setting must be reported to the department within 15 days.[10] Failure to comply with office surgery requirements may result, at the department's discretion, in probation, suspension, or revocation of office surgery registration; 50-200 hours of community service; and administrative fines of up to $10,000.[11]

Special Rules Relating to Liposuction

Liposuction is classified as a Level I or Level II office surgery procedure, depending on the type of anesthesia used. In any liposuction procedure, the surgeon is responsible for determining the appropriate amount of fat to be removed from the patient, up to a maximum of 4000 cc in the office surgical setting. Liposuction may be performed in combination with another surgical procedure during a single Level II or Level III operation if, when combined with abdominoplasty or when liposuction is associated with and directly related to another procedure, the total amount of fat removed does not exceed 1,000 cc.[12]

Any elective or cosmetic plastic surgery procedure or combination of procedures performed in a physician's office may not last longer than 8 continuous hours, and the patient must be discharged within 24 hours of presenting to the office for surgery. If the patient has not sufficiently recovered after 24 hours has elapsed, he or she must be transferred to a hospital for continued post-operative care. For all procedures other than cosmetic surgery, the patient must be discharged from the office by midnight on the day of surgery.[13]

Problems in South Florida

News media has reported the deaths of several South Floridians after liposuction procedures performed by physicians without sufficient training or equipment for cosmetic surgery. Many

[8] Rule 64B-4.003, F.A.C.
[9] Rule 64B8-9.0091, F.A.C. Identical provisions are found in Rule 64B15-14.0076, F.A.C.
[10] Rule 64B8-9.009(2), F.A.C. Identical provisions are found in Rule 64B15-14.007(2), F.A.C.
[11] Rule 64B8-8.001(2)(rr)9., F.A.C.
[12] Rule 64B8-9.009(2)(e), F.A.C. Identical provisions are found in Rule 64B15-14.007(2)(e), F.A.C.
[13] Rule 64B8-9.009(2)(f), F.A.C. Identical provisions are found in Rule 64B15-14.007(2)(f), F.A.C.

more Floridians have been permanently disfigured or live with chronic pain as a result of botched procedures from such physicians.

Current Florida law allows any licensed physician to perform office surgery. Physicians trained in specialties as disparate as radiology and ophthalmology are performing liposuction and other cosmetic surgeries in Florida because the field is lucrative and there is little insurance or government regulation over these elective procedures. The medical industry makes a distinction between plastic surgeons (physicians who spend at least 5 years training in nationally-accredited residency programs[14]) and cosmetic surgeons (physicians whose training in elective surgical procedures may take place over a weekend); however, the public is not generally aware of the difference.

Furthermore, physicians performing office surgeries under local anesthesia, including many liposuction procedures, are not required to register with or have their facilities inspected by the department. Many such unregulated cosmetic surgery facilities lack the necessary equipment to deal with emergent complications of surgical procedures and anesthesia, which has led to more negative outcomes for patients.[15]

III. Effect of Proposed Changes:

Section 1 amends s. 458.309(3), F.S., to require any allopathic physician who performs liposuction procedures in which more than 1,000 cc of fat is removed to register his or her office with the department unless the office is licensed as a facility under ch. 395, F.S. As a result, the office will be inspected annually by the department unless it already receives inspections through a nationally-recognized or department-approved accrediting organization.

Section 2 amends s. 459.005(2), F.S., to require any osteopathic physician who performs liposuction procedures in which more than 1,000 cc of fat is removed to register his or her office with the department unless the office is licensed as a facility under ch. 395, F.S. As a result, the office will be inspected annually by the department unless it already receives inspections through a nationally-recognized or department-approved accrediting organization.

Section 3 provides that the bill will take effect on January 3, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

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[14] Washington University School of Medicine Residency Web, *Length of Residencies*, available at http://residency.wustl.edu.beckerproxy.wustl.edu/medadmin/resweb.nsf/0ee53e934810efcd86256a94005e5f7d/3edd4e91945f8a2b86256f850071ae49?OpenDocument (last visited on November 8, 2011).

[15] USA Today, *Lack of training can be deadly in cosmetic surgery*, available at http://www.usatoday.com/money/perfi/basics/story/2011-09-13/cosmetic-surgery-investigation/50395494/1 (last visited on November 8, 2011).

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill requires physicians who perform office-based liposuction procedures in which more than 1,000 cc of fat is removed to register their offices with the department. These physicians will be required to pay a $150 registration fee and either a $1,500 annual fee for inspections or another fee to become accredited and receive inspections through any of the department-approved national accrediting organizations.

B. Private Sector Impact:

Physicians performing certain liposuction procedures will be subject to additional fees and regulations set by the department, including fees for registration and annual inspections.

C. Government Sector Impact:

The department will experience a recurring increase in workload relating to registration and inspection of additional office surgery facilities. The exact fiscal impact is indeterminate as the number of physicians who currently perform liposuction procedures removing greater than 1,000 cc of fat is unknown. The department will also experience non-recurring costs for rulemaking, updating the licensure database, and processing additional non-compliance complaints, which current resources are adequate to absorb.[16]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[16] Department of Health, *2012 Bill Analysis, Economic Statement, and Fiscal Note for SB 544*. A copy is on file with the Senate Health Regulation Committee.

VIII. Additional Information:

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

CS by Health Regulation on December 7, 2011:
The CS changes the effective date to January 3, 2013.

B. Amendments:

None.

By the Committee on Health Regulation; and Senator Sobel

588-01573-12 2012544c1

A bill to be entitled

An act relating to health care; amending ss. 458.309 and 459.005, F.S.; requiring that any physician or osteopathic physician who performs certain medical procedures in an office setting to register the office with the Department of Health unless that office is licensed as a facility under ch. 395, F.S., relating to hospital licensing and regulation; providing an effective date.

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

Section 1. Subsection (3) of section 458.309, Florida Statutes, is amended to read:

458.309 Rulemaking authority.—

(3) Any physician ~~All physicians~~ who performs liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed, ~~perform~~ level 2 procedures lasting more than 5 minutes, and all level 3 surgical procedures in an office setting must register the office with the department unless that office is licensed as a facility under ~~pursuant to~~ chapter 395. The department shall inspect the physician's office annually unless the office is accredited by a nationally recognized accrediting agency or an accrediting organization subsequently approved by the Board of Medicine. The actual costs for registration and inspection or accreditation shall be paid by the person seeking to register and operate the office setting in which office surgery is performed.

Section 2. Subsection (2) of section 459.005, Florida

588-01573-12 2012544c1

Statutes, is amended to read:

459.005 Rulemaking authority.—

(2) Any physician ~~All physicians~~ who performs liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed, ~~perform~~ level 2 procedures lasting more than 5 minutes, and all level 3 surgical procedures in an office setting must register the office with the department unless that office is licensed as a facility under ~~pursuant to~~ chapter 395. The department shall inspect the physician's office annually unless the office is accredited by a nationally recognized accrediting agency or an accrediting organization subsequently approved by the Board of Osteopathic Medicine. The actual costs for registration and inspection or accreditation shall be paid by the person seeking to register and operate the office setting in which office surgery is performed.

Section 3. This act shall take effect January 3, 2013.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 316
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Wise
SUBJECT:	Alzheimer's Disease
DATE:	January 19, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Farmer	CF	**Fav/CS**
2.	Brown	Hendon	BHA	**Favorable**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

This bill directs the Department of Elder Affairs (DOEA or "the department") to establish a public education program relating to screening for memory impairment. The bill also creates the memory-impairment screening grant program and authorizes DOEA to award grants in support of programs which provide information and education on the importance of memory screening as well as memory screening services. The bill establishes criteria for selecting grant recipients and requires that the department give preference to entities meeting certain requirements. Each grantee must submit an annual evaluation of its activities to the department. Additionally, DOEA must submit an annual report to the President of the Senate and the Speaker of the House of Representatives documenting the activities authorized by the bill.

Additionally, the bill makes technical changes relating to staff training requirements for persons assisting those with Alzheimer's disease.

The bill does not have a direct fiscal impact on government.

The bill amends the following sections of the Florida Statutes: 400.1755, 400.6045, and 429.178. This bill creates section 430.5025, Florida Statutes.

The bill has an effective date of July 1, 2012.

II. Present Situation:

Alzheimer's Disease

Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells and results in loss of memory, thinking, and language skills, and behavioral changes.[1] There are approximately 5.4 million Americans currently living with Alzheimer's disease, and that number is projected to rise to 16 million by 2050.[2] As the life expectancy for Americans has continued to rise, so has the number of new cases of Alzheimer's disease. For instance, in 2000 there were an estimated 411,000 new cases of Alzheimer's disease in the United States, and in 2010 that number was estimated to be 454,000 – a 10 percent increase.[3] That number is expected to rise to 959,000 new cases of Alzheimer's disease by 2050, a 130-percent increase from 2000.[4] Specifically in Florida, approximately 360,000 people age 65 or older had Alzheimer's disease in 2000 and in 2010, that number had risen to 450,000.

As the number of people with Alzheimer's disease increases, so does the cost of caring for these individuals. In 2011, the aggregate cost for health care, long-term care, and hospice for persons with Alzheimer's and other dementias was estimated to be $183 billion. That number is projected to be $1.1 trillion by 2050.[5] A major contributing factor to the cost of care for persons with Alzheimer's is that these individuals have more hospital stays, skilled nursing home stays, and home healthcare visits than older persons who do not have Alzheimer's. Research shows that 22 percent of individuals with Alzheimer's disease who have Medicare also have Medicaid coverage, which pays for nursing home care and other long-term care services.[6] The total Medicaid spending for people with Alzheimer's disease (and other dementia) was estimated to be $37 billion in 2011.[7]

In addition to the cost of health care, there is a significant cost associated with unpaid caregivers. An unpaid caregiver is primarily a family member, but can also be other relatives or friends. Such caregivers often provide assistance with daily activities, such as shopping for groceries, preparing meals, bathing, dressing, grooming, assisting with mobility, helping the person take medications, making arrangements for medical care, and performing other household chores. Nationally, in 2010, nearly 15 million unpaid caregivers provided an estimated 17 billion hours of unpaid care, valued at $202.6 billion.[8] In 2010, there were 960,037 caregivers in Florida with an estimated value of unpaid care reaching nearly $13.5 million.[9]

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[1] Alzheimer's Foundation of America, *About Alzheimer's, Definition of Alzheimer's,* http://www.alzfdn.org/AboutAlzheimers/definition.html (last visited Aug. 2, 2011).
[2] Alzheimer's Assn., *Fact Sheet: 2011 Alzheimer's Disease Facts and Figures* (March 2011), *available at* http://www.alz.org/documents_custom/2011_Facts_Figures_Fact_Sheet.pdf (last visited Aug. 3, 2011).
[3] Alzheimer's Assn., *2011 Alzheimer's Disease Facts and Figures*, 7 ALZHEIMER'S & DEMENTIA (Issue 2) at 17, *available at* http://www.alz.org/downloads/Facts_Figures_2011.pdf (last visited Oct. 27, 2011).
[4] *Id*.
[5] *Id.* at 35.
[6] *Id*.
[7] *Id*. at 44.
[8] This number was established by using an average of 21.9 hours of care a week with a value of $11.93 per hour. *Id.* at 27.
[9] *Id*. at 32.

Alzheimer's disease is the nation's sixth leading cause of death with an average life expectancy of four to eight years after diagnosis.[10] In Florida, 4,644 people died of complications related to Alzheimer's disease in 2007.[11]

Memory Screening and Early Diagnosis

Alzheimer's disease can only be confirmed by an autopsy; however, clinicians can attempt to diagnose the disease by taking a complete medical history and conducting lab tests, a physical exam, brain scans, and neuro-psychological tests that gauge memory, attention, language skills, and problem-solving abilities. Using these methods, clinicians are able to diagnose Alzheimer's disease with up to 90-percent accuracy.[12] Although there is no known cure for Alzheimer's disease, the U.S. Food and Drug Administration has approved a few medications that have been found to help control symptoms or slow the progression of the disease.[13] Thus, early detection of the disease enhances the possibility of effective treatment. Early diagnosis can also enable patients to participate in decisions regarding their care.

Memory screenings consist of a series of questions or tasks designed to test memory and other intellectual functions. They are not used to diagnose any particular illness, but can be very helpful in indicating whether an individual would benefit from further testing to identify Alzheimer's disease, related dementias, or other possible causes of symptoms which mimic Alzheimer's disease.[14] These screenings are typically provided by professionals such as social workers, pharmacists, nurses, and doctors.

Alzheimer's Disease Initiative

The Alzheimer's Disease Initiative (ADI) was legislatively created in 1985 to provide a continuum of services to meet the changing needs of individuals with, and families affected by, Alzheimer's disease and related disorders. The Initiative has four objectives: (1) to provide supportive services; (2) to establish memory disorder clinics; (3) to provide model day care programs to test new care alternatives; and (4) to establish a research database and brain bank to support research.[15] There are 15 memory disorder clinics throughout the state, 13 of which are state funded.[16] The purpose of these clinics is to conduct research related to diagnostic technique, therapeutic interventions, and supportive services for persons with Alzheimer's disease and to develop caregiver-training materials.[17] According to ADI, the memory disorder clinics are required to:

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[10] *Id.* at 23.
[11] *Id.* at 22.
[12] Alzheimer's Foundation of America, *About Alzheimer's, Diagnosis*, http://www.alzfdn.org/AboutAlzheimers/diagnosis.html (last visited Aug. 2, 2011).
[13] To see a list of FDA approved medications, go to the Alzheimer's Foundation of America, *About Alzheimer's Treatment,* http://www.alzfdn.org/AboutAlzheimers/treatment.html (last visited Aug. 3, 2011).
[14] Alzheimer's Foundation of America, *Brain Health,* http://www.alzfdn.org/BrainHealth/memoryscreenings.html (last visited Oct. 24, 2011).
[15] Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, http://elderaffairs.state.fl.us/english/alz.php (last visited Aug. 16, 2011).
[16] *Id*.
[17] Section 430.502(2), F.S.

- Provide services to persons suspected of having Alzheimer's disease or other related dementia;
- Provide four hours of in-service training during the contract year to all ADI respite and model day care service providers and develop and disseminate training models to service providers and the Department of Elder Affairs;
- Develop training materials and educational opportunities for lay and professional caregivers and provide specialized training for caregivers and caregiver organizations;
- Conduct service-related applied research;
- Establish a minimum of one annual contact with each respite care and model day care service provider to discuss, plan, develop, and conduct service-related research projects; and
- Plan for the public dissemination of research findings through professional papers and to the general public.[18]

Multi-disciplinary teams provide comprehensive evaluations, treatment recommendations, long-term care strategies, and follow-up services to patients, caregivers, and families. The memory disorder clinics offer a full range of tests to determine whether thinking difficulties and symptoms of forgetfulness are a result of everyday life pressures, or the sign of a memory disorder. The memory disorder clinics offer free and confidential memory screenings, medical evaluations, follow-up resources, and educational material about memory concerns and successful aging. In addition, each November during "National Memory Screening Day," the clinics participate in a collaborative effort with the Alzheimer's Foundation of America to promote early detection of Alzheimer's disease and related illnesses and to encourage appropriate intervention.[19]

Individuals diagnosed with or suspected of having Alzheimer's disease are eligible for memory disorder clinic services. In fiscal year 2009-2010, Florida's memory disorder clinics received nearly $3 million in state funds and served just over 5,000 clients.[20]

III. Effect of Proposed Changes:

This bill directs the Department of Elder Affairs (DOEA or department) to develop and implement a public education program relating to screening for memory impairment and the importance of early diagnosis and treatment of Alzheimer's disease.

The bill also creates the memory-impairment screening grant program and authorizes DOEA to award grants to qualifying entities to support programs that provide information and education on the importance of memory screening for early diagnosis and treatment of Alzheimer's disease and related disorders and that provide screenings for memory impairment. The bill defines the term "qualifying entities" as any "public or nonprofit private entities that provide services and

[18] Dep't of Elder Affairs, *Summary of Programs and Services*, 87-88 (Feb. 2011), *available at* http://elderaffairs.state.fl.us/english/pubs/pubs/sops2011/Files/2011_SOPS_full%20web.pdf (last visited Aug. 16, 2011).
[19] Dep't of Elder Affairs, *2012 Legislative Bill Analysis, SB 316* (Oct. 26, 2011) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[20] *Summary of Programs and Services*, *supra* note 18, at 91.

care to individuals who have Alzheimer's disease or related disorders and their caregivers and families."

The bill provides that DOEA shall give preference to applicants that:

- Have demonstrated experience in promoting public education and awareness of the importance of memory screening or providing memory-screening services;
- Have established arrangements with health care providers and other organizations to provide screenings for memory impairment in a manner that is convenient to individuals in the communities served by the applicants; and
- Provide matching funds.

The bill requires each entity that receives a grant to submit an annual evaluation to the department describing the activities carried out with the funds received and the long-term effectiveness of such activities in promoting early detection of memory impairment. Additionally, DOEA must submit an annual report to the President of the Senate and the Speaker of the House of Representatives describing the activities carried out, including provisions describing the extent to which the activities have affected the rate of screening for memory impairment and have improved outcomes for patients and caregivers.

The bill authorizes DOEA to set aside up to 15 percent of the total amount appropriated to the memory-impairment screening grant program for the fiscal year to provide technical assistance to the grantees.

The bill provides an implementation section, specifying that the public education program created by the bill shall operate within existing resources of DOEA and the memory-impairment screening grant program is contingent upon appropriation of state funds or the availability of private resources.

Finally, the bill makes technical changes relating to staff training requirements for persons assisting those with Alzheimer's disease.

The bill has an effective date of July 1, 2012.

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:

This bill will provide public and nonprofit private entities that provide services and care to individuals who have Alzheimer's disease or related disorders the opportunity to apply for a state grant to support the development, expansion, or operation of programs that provide screenings for memory impairment and information and education on the importance of memory screening.[21]

C. Government Sector Impact:

The bill does not have a direct fiscal impact on government. Two provisions could require resources:

- Public Education: The Department of Elder Affairs currently contracts with 13 memory disorder clinics to provide services to individuals with memory problems and to their families and caregivers. Accordingly, the department can develop and implement the public education program portion of this bill within existing resources.[22]
- Grant Program: The bill provides that implementation of the grant program is contingent upon an appropriation of state funds or the availability of private resources, which would require a specific appropriation for the department to award grants to entities as specified in the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Children, Families, and Elder Affairs on November 3, 2011:
The committee substitute specifically creates the memory-impairment screening grant program, which is to be administered by the Department of Elder Affairs (DOEA or department). The committee substitute also provides that an entity receiving a grant shall submit an evaluation to DOEA annually describing activities conducted with the funds.

[21] *2012 Legislative Bill Analysis, supra* note 19.
[22] *Id*.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and Senator Wise

586-00843-12 2012316c1

A bill to be entitled

An act relating to Alzheimer's disease; creating s. 430.5025, F.S.; directing the Department of Elderly Affairs to develop and implement a public education program relating to screening for Alzheimer's disease; creating the memory-impairment screening grant program; providing criteria for awarding grants; providing a definition; requiring grant recipients to submit an evaluation of certain activities to the department; authorizing the department to provide technical support; requiring an annual report to the Legislature; providing for implementation of the public education program to operate within existing resources of the department; providing that implementation of the memory-impairment screening grant program is contingent upon an appropriation of state funds or the availability of private resources; amending s. 400.1755, F.S.; specifying the types of facilities where an employee or direct caregiver providing care for persons with Alzheimer's disease may begin employment without repeating certain training requirements; amending s. 400.6045, F.S.; requiring direct caregivers to comply with certain continuing education requirements; amending s. 429.178, F.S.; specifying the types of facilities where an employee or direct caregiver providing care for persons with Alzheimer's disease may begin employment without repeating certain training requirements; providing an effective date.

Florida Senate - 2012 CS for SB 316

586-00843-12 2012316c1

WHEREAS, Alzheimer's disease is a slow, progressive disorder of the brain which results in loss of memory and other cognitive functions, is the eighth leading cause of death in the United States, and currently affects an estimated 5 million Americans, with that number expected to increase to 16 million by mid-century, and

WHEREAS, Alzheimer's disease strikes approximately 1 in 10 people over the age of 65 and nearly one-half of those who are age 85 or older, although some people develop symptoms as young as age 40, and

WHEREAS, Alzheimer's disease takes an enormous toll on family members who are the caregivers for individuals having the disease, and

WHEREAS, caregivers for individuals who have Alzheimer's disease suffer more stress, depression, and health problems than caregivers for individuals who have other illnesses, and

WHEREAS, Alzheimer's disease costs United States businesses more than $60 billion annually due to lost productivity and absenteeism by primary caregivers and increased insurance costs, and

WHEREAS, recent advancements in scientific research have demonstrated the benefits of early medical treatment for persons who have Alzheimer's disease and the benefits of early access to counseling and other support services for their caregivers, and

WHEREAS, research shows that several medications have been developed which can reduce the symptoms of Alzheimer's disease, that persons begin to benefit most when these medications are taken in the early stages of a memory disorder, and that this

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

intervention may extend the period during which patients can be cared for at home, thereby significantly reducing the costs of institutional care, and

WHEREAS, with early diagnosis, patients can participate in decisions regarding their care and their families can take advantage of support services that can reduce caregiver depression and related health problems, and

WHEREAS, in direct response to research breakthroughs, National Memory Screening Day was established as a collaborative effort by organizations and health care professionals across the country to promote awareness and early detection of memory impairments, and

WHEREAS, on National Memory Screening Day, which is held on the third Tuesday of November in recognition of National Alzheimer's Disease Month, health care professionals administer free memory screenings at hundreds of sites throughout the United States, and

WHEREAS, memory screening is used as an indicator of whether a person might benefit from more extensive testing to determine whether a memory or cognitive impairment exists and identifies persons who may benefit from medical attention, but is not used to diagnose any illness and in no way replaces examination by a qualified physician, NOW, THEREFORE,

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

Section 1. Section 430.5025, Florida Statutes, is created to read:

430.5025 Memory-impairment screening; grants.—

(1) The Department of Elderly Affairs shall develop and implement a public education program relating to screening for memory impairment and the importance of early diagnosis and treatment of Alzheimer's disease and related disorders.

(2)(a) The memory-impairment screening grant program is created and shall be administered by the department.

(b) The department may award grants to qualifying entities to support the development, expansion, or operation of programs that provide:

1. Information and education on the importance of memory screening for early diagnosis and treatment of Alzheimer's disease and related disorders.

2. Screenings for memory impairment.

(3) As used in this section, the term "qualifying entities" means public and nonprofit private entities that provide services and care to individuals who have Alzheimer's disease or related disorders and their caregivers and families.

(4) When awarding grants under this section, the department shall give preference to applicants that:

(a) Have demonstrated experience in promoting public education and awareness of the importance of memory screening or providing memory-screening services.

(b) Have established arrangements with health care providers and other organizations to provide screenings for memory impairment in a manner that is convenient to individuals in the communities served by the applicants.

(c) Provide matching funds.

(5) A qualifying entity that receives a grant under this section shall submit to the department an annual evaluation that

describes activities carried out with funds received under this section, the long-term effectiveness of such activities in promoting early detection of memory impairment, and any other information that the department requires.

(6) The department may set aside an amount not to exceed 15 percent of the total amount appropriated to the memory-impairment screening grant program for the fiscal year to provide grantees with technical support in the development, implementation, and evaluation of memory-impairment screening programs.

(7) A grant may be awarded under subsection (2) only if an application for the grant is submitted to the department and the application is in the form, is made in the manner, and contains the agreements, assurances, and information that the department determines are necessary to carry out the purposes of this section.

(8) The department shall annually submit to the President of the Senate and the Speaker of the House of Representatives a report on the activities carried out under this section, including provisions describing the extent to which the activities have affected the rate of screening for memory impairment and have improved outcomes for patients and caregivers.

Section 2. Implementation.—

(1) Implementation of the public education program created under s. 430.5025, Florida Statutes, shall operate within existing resources of the Department of Elderly Affairs.

(2) Implementation of the memory-impairment screening grant program created under s. 430.5025, Florida Statutes, is

contingent upon appropriation of state funds or the availability of private resources.

Section 3. Subsection (6) of section 400.1755, Florida Statutes, is amended to read:

400.1755 Care for persons with Alzheimer's disease or related disorders.—

(6) Upon completing any training listed in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility or to an assisted living facility, home health agency, adult day care center, or hospice ~~adult family-care home~~. The direct caregiver must comply with other applicable continuing education requirements.

Section 4. Paragraph (h) of subsection (1) of section 400.6045, Florida Statutes, is amended to read:

400.6045 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.—

(1) A hospice licensed under this part must provide the following staff training:

(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the

identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to a home health agency, assisted living facility, nursing home, or adult day care center. The direct caregiver must comply with other applicable continuing education requirements.

Section 5. Subsection (4) of section 429.178, Florida Statutes, is amended to read:

429.178 Special care for persons with Alzheimer's disease or other related disorders.—

(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different assisted living facility or nursing home, hospice, adult day care center, or home health agency ~~facility~~. The employee or direct caregiver must comply with other applicable continuing education requirements.

Section 6. This act shall take effect July 1, 2012.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 450
INTRODUCER:	Health Regulation Committee and Senator Oelrich
SUBJECT:	Emergency Medical Services
DATE:	January 19, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Steele	Stovall	HR	**Fav/CS**
2.	Hinton	Yeatman	CA	**Favorable**
3.	Bradford	Hendon	BHA	**Favorable**
4.			BC	
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

This bill deletes the requirement for emergency medical technicians (EMTs), paramedics, and 911 public safety telecommunicators, certified under ch. 401, F.S., to complete a course approved by the Department of Health (DOH), regarding the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) as a condition of certification and recertification. The bill updates Florida's EMT and paramedic training requirements to reflect the 2009 national training standards.

The bill redefines "basic life support" to include the name of the new National EMS Education Standards and changes the timetable for revision of the comprehensive state plan for emergency medical services and programs from biennially to every 5 years.

This fiscal impact on the Department of Health is minimal and can be absorbed within its current resources.

This bill substantially amends the following sections of the Florida Statutes: 381.0034, 401.23, 401.24, 401.27, and 401.2701.

II. Present Situation:

Acquired Immune Deficiency Syndrome is a physical disorder that results in the loss of immunity in affected persons. It is caused by a retrovirus known as the Human Immunodeficiency Virus. The HIV infection and AIDS remain leading causes of illness and death in the United States. The Centers for Disease Control and Prevention (CDC) estimated that at the end of 2006 over 1 million persons in the United States were living with HIV/AIDS.[1] According to the CDC, the annual number of AIDS cases and deaths declined substantially after 1994, but stabilized during the period 1999-2004.[2] The number of HIV/AIDS cases among racial/ethnic minority populations and persons exposed to HIV through heterosexual contact has increased since 1994.[3] Florida ranks third[4] among the states in the cumulative number of reported AIDS cases, with 123,112 cases reported through August 2011.[5]

The HIV infection can be transmitted through certain body fluids (blood, semen, vaginal secretions, and breast milk) from an HIV-infected person. These specific fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the blood-stream (from a needle or syringe) for transmission to possibly occur. In the United States, HIV is most commonly transmitted through specific sexual behaviors (anal or vaginal sex) or sharing needles with an infected person.[6]

EMTs and paramedics can be exposed to blood because they treat trauma victims and perform advanced life support procedures using needles and other sharp instruments. They often work under unpredictable, adverse conditions where patients may be experiencing uncontrolled bleeding or disorientation. Exposure to blood can occur from a sharps injury, such as a needlestick after use on a patient or a cut from a contaminated sharp object. Exposure can also occur from a splash to the eyes, nose, or mouth; contact on non-intact (broken or cracked) skin; or a human bite.

According to the CDC, implementation of *Standard Precautions* constitutes the primary strategy for the prevention of health care-associated transmission of infectious agents among patients and health care personnel. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which health care is delivered. These include: hand hygiene; use of gloves, gown,

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[1] *HIV in the United States: An Overview*, Revised July 2010, CDC. Found at: <http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/us_overview.pdf> (Last visited on December 5, 2011).
[2] CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. MMWR (Morbidity and Mortality Weekly Report), September 22, 2006; 55(RR 14):1-17. Found at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm> (Last visited on December 5, 2011).
[3] *Id.*
[4] Florida – 2010 Profile. Found at: <http://www.cdc.gov/nchhstp/stateprofiles/pdf/florida_profile.pdf> (Last visited on December 5, 2011).
[5] The Florida Department of Health, Division of Disease Control, *Monthly Surveillance Report* (Hepatitis, HIV/AIDS, STD and TB), September 2011, p. 16. Found at: <http://www.doh.state.fl.us/disease_ctrl/aids/trends/msr/2011/MSR0911b.pdf> (Last visited on December 5, 2011).
[6] CDC, HIV Transmission, *How is HIV passed from one person to another?* Found at: <http://www.cdc.gov/hiv/resources/qa/transmission.htm> (Last visited on December 5, 2011).

mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).[7]

The CDC and state health departments have been investigating cases of HIV infection in health care personnel without identified risk factors since the early days of the AIDS epidemic. Of those health care personnel for whom case investigations were completed from 1981 to 2010, 57 had documented seroconversion to HIV following occupational exposures. In addition, 143 possible cases of HIV infection have been reported among health care personnel.[8] According to the CDC, there were no documented cases of emergency medical technicians or paramedics having acquired an HIV infection through occupational exposure. However, there were 12 EMTs/paramedics for whom occupational acquisition of an HIV infection might have been possible.[9]

Emergency Medical Technicians/Paramedics, Standards and Certification

The Department of Health, Division of Emergency Operations regulates EMTs and paramedics. "Emergency Medical Technician" is defined under s. 401.23, F.S., to mean a person who is certified by the DOH to perform basic life support, which is the treatment of medical emergencies through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the U.S. Department of Transportation. "Paramedic" means a person who is certified by the DOH to perform basic *and* advanced life support.

The DOH must establish, by rule, educational and training criteria and examinations for the certification and recertification of EMTs and paramedics.[10] An applicant for certification or recertification as an EMT or paramedic must have completed an appropriate training course as follows:

- For an EMT, an emergency medical technician training course equivalent to the most recent emergency medical technician basic training course of the U.S. Department of Transportation as approved by the DOH.
- For a paramedic, a paramedic training program equivalent to the most recent paramedic course of the U.S. Department of Transportation as approved by the DOH.

The DOH must also establish by rule, a procedure for biennial renewal of certification of EMTs and paramedics. Such rules for EMTs must require a U.S. Department of Transportation refresher training program of at least 30 hours as approved by the DOH every 2 years. Rules for

[7] Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee, CDC, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, p. 66. Found at: <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf> (Last visited on December 5, 2011).
[8] CDC, *Surveillance of Occupationally Acquired HIV/AIDS in Healthcare Personnel, as of December 2010*, updated May, 2011. Available at: <http://www.cdc.gov/HAI/organisms/hiv/Surveillance-Occupationally-Acquired-HIV-AIDS.html> (Last visited on December 5, 2011).
[9] *Id.*
[10] Section 401.27, F.S.

paramedics must require candidates for renewal to have taken at least 30 hours of continuing education units during the 2-year period.

911 Public Safety Telecommunicator[11]

"911 public safety telecommunicator" means a public safety dispatch or 911 operator whose duties include, among other things, answering, receiving, transferring, and dispatching functions related to 911 calls and dispatching law enforcement officers, fire rescue services, emergency medical services, and other public safety services to the scene of an emergency. Certain 911 public safety telecommunicators are required to be certified pursuant to s. 401.465, F.S. The DOH is to establish, by rule, educational and training criteria for the certification and recertification of 911 public safety telecommunicators.

Requirement for Instruction on HIV/AIDS

In 2006, the Legislature revised the requirements for the HIV/AIDS continuing education instruction in the general licensing provisions for health practitioners regulated by s. 456.033, F.S.[12] These practitioners are no longer required to take a course on HIV/AIDS as a condition of initial licensure. They are required to complete a continuing education course on HIV/AIDS for their first licensure renewal.

Under s. 381.0034(3), F.S., the DOH must require applicants for initial licensure or certification as EMTs, paramedics, 911 public safety telecommunicators, midwives, radiologic technologists, or clinical laboratory personnel to complete an educational course on HIV and AIDS. These professions must complete a department-approved course on HIV/AIDS at the time of initial licensure or certification, or do so within 6 months of licensure or certification upon an affidavit showing good cause.

The course must cover modes of transmission, infection control procedures, clinical management, and prevention of HIV/AIDS. The course must also include information on current Florida law on AIDS and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to HIV counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification. Failure to comply with the educational requirement is grounds for disciplinary action.[13]

Section 381.0034(1), F.S., also provides that the DOH must require, as a condition of biennial relicensure, persons certified or licensed as EMTs, paramedics, 911 public safety telecommunicators, midwives, radiologic technologists, and clinical laboratory personnel to complete an educational course approved by the DOH on HIV/AIDS. Each licensee or certificate holder is to submit confirmation of having completed the course when submitting fees or an application for each biennial renewal.

[11] Section 401.465, F.S.
[12] *See* Chapter 2006-251, L.O.F.
[13] Section 381.0034(2), F.S.

Emergency Medical Services Training Programs[14]

Any private or public institution in Florida desiring to conduct an approved program for the education of EMTs and paramedics must submit a completed application, which must include documentation verifying that the curriculum:

- Meets the course guides and instructor's lesson plans in the most recent Emergency Medical Technician-Basic: National Standard Curricula for emergency medical technician programs and Emergency Medical Technician-Paramedic: National Standard Curricula for paramedic programs;
- Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the DOH by rule; and
- Includes 4 hours of instruction on HIV/AIDS training consistent with the requirements of ch. 381, F.S.

EMT and Paramedic National Standard Curricula

The National Highway Traffic Safety Administration (NHTSA) has assumed responsibility for the development of training courses that are responsive to the standards established by the Highway Safety Act of 1966 (amended). These courses are designed to provide national guidelines for training.

In 1994, the NHTSA completed an extensive revision of the national standard Emergency Medical Technician-Basic Curriculum.[15] The EMT-Basic: National Standard Curriculum is a core curriculum of minimum required information, to be presented within a 110-hour training program, intended to prepare a medically competent EMT-Basic to operate in the field. The 110-hour time constraint of the program, as recommended by the national emergency medical services community during the 1990 NHTSA *Consensus Workshop on Emergency Medical Services Training Programs*, necessitates the need for enrichment and continuing education in order to bring a student to full competency.[16]

The topic of HIV/AIDS is not specifically addressed in the EMT-Basic: National Standard Curriculum. The topic is most likely to be covered in the module of the curriculum that addresses the well-being of the EMT-Basic. This module covers body substance isolation, personal protection from airborne and blood borne pathogens, personal protection equipment, and safety precautions.

The 1994 EMT-Basic: National Standard Curriculum Instructor's Course Guide specifically mentions that: "It is important to understand that this curriculum does not provide students with extensive knowledge in hazardous materials, blood-borne pathogens, emergency vehicle operations or rescue practices in unusual environments. These areas are not core elements of education and practice as identified in the *National EMS Education and Practice Blueprint*. Identified areas of competency not specifically designed within the EMT-Basic: National

[14] Section 401.2701, F.S.
[15] National Standard Curriculum. Found at: <http://www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf> (Last visited on December 5, 2011).
[16] *Id., p. 25.*

Standard Curriculum should be taught in conjunction with this program as a local or state option."[17]

The EMT-Paramedic: National Standard Curriculum represents the minimum required information to be presented within a course leading to certification as a paramedic. It is recognized that there is additional specific education that will be required of paramedics who operate in the field, i.e., ambulance driving, heavy and light rescue, basic extrication, special needs, and so on. It is also recognized that this information might differ from locality to locality, and that each training program or system should identify and provide special instruction for these training requirements.[18]

The EMT-Basic certification is a prerequisite for the more advanced paramedic education, so the topic of HIV/AIDS would most likely have already been covered by the EMT-Basic: National Standard Curriculum.

The 1998 EMT-Paramedic: National Standard Curriculum Introduction also specifically mentions that: "It is important to recognize that this curriculum does not provide students with extensive knowledge in hazardous materials, blood-borne pathogens, emergency vehicle operations or rescue practices in unusual environments. These areas are not core elements of education and practice as identified in the *National EMS Education and Practice Blueprint*. Identified areas of competency not specifically designed within the EMT-Paramedic: National Standard Curriculum should be taught in conjunction with this program as a local or state option."[19]

The National EMS Education Standards[20]

The National EMS Education Standards (Standards), led by the National Association of EMS Educators, replace the NHTSA National Standard Curricula at all licensure levels. The Standards define the competencies, clinical behaviors, and judgments that must be met by entry-level EMS personnel to meet practice guidelines defined in the National EMS Scope of Practice Model. Content and concepts defined in the National EMS Core Content are also integrated within the Standards.

The Standards are comprised of four components:

- Competency - This statement represents the minimum competency required for entry-level personnel at each licensure level.
- Knowledge Required to Achieve Competency - This represents an elaboration of the knowledge within each competency (when appropriate) that entry-level personnel would need to master in order to achieve competency.
- Clinical Behaviors/Judgments - This section describes the clinical behaviors and judgments essential for entry-level EMS personnel at each licensure level.

[17] *Id.*, p. 25.
[18] EMT: Paramedic National Standard Curriculum, *Preface*. Found at: <http://www.nhtsa.gov/people/injury/ems/EMT-P/disk_1%5B1%5D/Intro.pdf> (Last visited on December 5, 2011).
[19] *Id.*, p. 19-20.
[20] National Emergency Medical Services Education Standards. Found at: <http://www.ems.gov/pdf/811077a.pdf> (Last visited on December 5, 2011).

- Educational Infrastructure - This section describes the support standards necessary for conducting EMS training programs at each licensure level.

Each statement in the Standards presumes that the expected knowledge and behaviors are within the scope of practice for that EMS licensure level, as defined by the National EMS Scope of Practice Model. Each competency applies to patients of all ages, unless a specific age group is identified.

The Standards also assume there is a progression in practice from the Emergency Medical Responder level to the Paramedic level. That is, licensed personnel at each level are responsible for all knowledge, judgments, and behaviors at their level and at all levels preceding their level. For example, a Paramedic is responsible for knowing and doing everything identified in that specific area, as well as knowing and doing all tasks in the three preceding levels.

The National EMS Education Standards do not specifically address the topic of HIV/AIDS. Like the National Standard Curricula mentioned above, the Standards cover adherence to Standard Precautions, blood borne pathogens, and disease transmission prevention.

Emergency Medical Services State Plan[21]

The DOH is responsible for the improvement and regulation of basic and advanced life support programs and is required to biennially develop and revise a comprehensive state plan for basic and advanced life support services.

III. Effect of Proposed Changes:

Section 1 amends s. 381.0034, F.S., to remove the requirement for each person certified under ch. 401, F.S., Medical Telecommunications and Transportation, to complete an educational course about HIV and AIDS as a condition of initial certification and renewal of certification. It also makes technical changes.

Section 2 amends s. 401.23, F.S., to define "basic life support" as treatment of medical emergencies by a qualified person through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum or the National EMS Education Standards of the United States Department of Transportation as approved by the DOH. The bill removes a list of techniques that are examples of the techniques of basic life support.

Section 3 amends s. 401.24, F.S., relating to the emergency medical services state plan, to require the DOH to develop and revise the comprehensive state plan every 5 years rather than every 2 years.

Section 4 amends s. 401.27, F.S., relating to ambulance personnel standards and certification, to require the completion of a training course equivalent to the most recent National EMS Education Standards, as approved by the DOH, in order for a person to apply for certification or

[21] Section 401.24, F.S.

recertification as an EMT or paramedic. The bill extends the timeframe to pass the examination to become certified as an EMT or paramedic from 1 to 2 years following successful course completion.

Section 5 amends s. 401.2701, F.S., relating to emergency medical services training programs, to include the National EMS Education Standards as a curriculum option for EMT and paramedic training programs. It also makes technical changes.

Section 6 provides an effective date of July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH indicated that the bill would require the department to promulgate rules to remove the HIV/AIDS requirement in 64J-1.008 and 64J-1.009, F.A.C. In addition, the DOH will need to revise a form, publish notice of the rule changes and hold a public hearing with associated overhead costs. The DOH indicated that the fiscal impact will be

minimal and can be absorbed within the department's Emergency Medical Services Trust Fund.[22]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Regulation Committee on December, 7, 2011:
The title was revised to include 911 public safety telecommunicators, which is included in Chapter 401. Grammatical changes were made to clarify that the training courses must be approved by the DOH and language that had been inadvertently struck concerning the training curricula for paramedics was reinstated.

B. Amendments:

None.

[22] Department of Health, *Senate Bill 450 Bill Analysis, Economic Statement and Fiscal Note* (October 27, 2011) (on file with the Senate Committee on Community Affairs)

By the Committee on Health Regulation; and Senator Oelrich

588-01570-12 2012450c1

A bill to be entitled

An act relating to emergency medical services; amending s. 381.0034, F.S.; deleting the requirement for emergency medical technicians, paramedics, and 911 public safety telecommunicators to complete an educational course on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome; amending s. 401.23, F.S.; redefining the term "basic life support" for purposes of the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act; amending s. 401.24, F.S.; revising the period for review of the comprehensive state plan for emergency medical services and programs; amending s. 401.27, F.S.; revising the requirements for certification or recertification as an emergency medical technician or paramedic; revising the requirements for certification for an out-of-state trained emergency medical technician or paramedic; amending s. 401.2701, F.S.; revising requirements for an institution that conducts an approved program for the education of emergency medical technicians and paramedics; revising the requirements that students must meet in order to receive a certificate of completion from an approved program; providing an effective date.

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

588-01570-12 2012450c1

Section 1. Subsection (1) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—(1) As of July 1, 1991, the Department of Health shall require each person licensed or certified under ~~chapter 401,~~ chapter 467, part IV of chapter 468, or chapter 483, as a condition of biennial relicensure, to complete an educational course approved by the department on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current state ~~Florida~~ law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, and treatment of patients. Each such licensee or certificateholder shall submit confirmation of having completed the ~~said~~ course, on a form provided by the department, when submitting fees or application for each biennial renewal.

Section 2. Subsection (7) of section 401.23, Florida Statutes, is amended to read:

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

(7) "Basic life support" means treatment of medical emergencies by a qualified person through the use of techniques ~~such as patient assessment, cardiopulmonary resuscitation (CPR), splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, administration of a subcutaneous injection using a premeasured autoinjector of epinephrine to a person suffering an anaphylactic reaction, and other techniques~~ described in the Emergency Medical Technician Basic Training Course Curriculum or

the National EMS Education Standards of the United States Department of Transportation, and as approved by the department. The term ~~"basic life support"~~ also includes other techniques that ~~which~~ have been approved and are performed under conditions specified by rules of the department.

Section 3. Section 401.24, Florida Statutes, is amended to read:

401.24 Emergency medical services state plan.—The department is responsible, at a minimum, for the improvement and regulation of basic and advanced life support programs. The department shall develop, and ~~biennially~~ revise every 5 years, a comprehensive state plan for basic and advanced life support services, the emergency medical services grants program, trauma centers, the injury control program, and medical disaster preparedness. The state plan shall include, but need not be limited to:

(1) Emergency medical systems planning, including the prehospital and hospital phases of patient care, and injury control effort and unification of such services into a total delivery system to include air, water, and land services.

(2) Requirements for the operation, coordination, and ongoing development of emergency medical services, which includes: basic life support or advanced life support vehicles, equipment, and supplies; communications; personnel; training; public education; state trauma system; injury control; and other medical care components.

(3) The definition of areas of responsibility for regulating and planning the ongoing and developing delivery service requirements.

Section 4. Subsections (4) and (12) of section 401.27, Florida Statutes, are amended to read:

401.27 Personnel; standards and certification.—

(4) An applicant for certification or recertification as an emergency medical technician or paramedic must:

(a) Have completed an appropriate training course as follows:

1. For an emergency medical technician, an emergency medical technician training course equivalent to the most recent national standard curriculum or National EMS Education Standards ~~emergency medical technician basic training course~~ of the United States Department of Transportation, and as approved by the department;

2. For a paramedic, a paramedic training program equivalent to the most recent national standard curriculum or National EMS Education Standards ~~paramedic course~~ of the United States Department of Transportation, and as approved by the department;

(b) Certify under oath that he or she is not addicted to alcohol or any controlled substance;

(c) Certify under oath that he or she is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;

(d) Within 2 years ~~1 year~~ after course completion have passed an examination developed or required by the department;

(e)1. For an emergency medical technician, hold ~~either~~ a current American Heart Association cardiopulmonary resuscitation course card or an American Red Cross cardiopulmonary resuscitation course card or its equivalent as defined by department rule;

2. For a paramedic, hold a certificate of successful course completion in advanced cardiac life support from the American Heart Association or its equivalent as defined by department rule;

(f) Submit the certification fee and the nonrefundable examination fee prescribed in s. 401.34, which examination fee will be required for each examination administered to an applicant; and

(g) Submit a completed application to the department, which application documents compliance with paragraphs (a), (b), (c), (e), (f), (g), and, if applicable, (d). The application must be submitted so as to be received by the department at least 30 calendar days before the next regularly scheduled examination for which the applicant desires to be scheduled.

(12) An applicant for certification who is an out-of-state trained emergency medical technician or paramedic must provide proof of current emergency medical technician or paramedic certification or registration based upon successful completion of the United States Department of Transportation emergency medical technician or paramedic training curriculum or the National EMS Education Standards, and as approved by the department, and hold a current certificate of successful course completion in cardiopulmonary resuscitation (CPR) or advanced cardiac life support for emergency medical technicians or paramedics, respectively, to be eligible for the certification examination. The applicant must successfully complete the certification examination within 1 year after the date of the receipt of his or her application by the department. After 1 year, the applicant must submit a new application, meet all

eligibility requirements, and submit all fees to reestablish eligibility to take the certification examination.

Section 5. Paragraph (a) of subsection (1) and subsection (5) of section 401.2701, Florida Statutes, are amended to read:

401.2701 Emergency medical services training programs.—

(1) Any private or public institution in Florida desiring to conduct an approved program for the education of emergency medical technicians and paramedics shall:

(a) Submit a completed application on a form provided by the department, which must include:

1. Evidence that the institution is in compliance with all applicable requirements of the Department of Education.

2. Evidence of an affiliation agreement with a hospital that has an emergency department staffed by at least one physician and one registered nurse.

3. Evidence of an affiliation agreement with a current ~~Florida-licensed~~ emergency medical services provider that is licensed in this state. Such agreement shall include, at a minimum, a commitment by the provider to conduct the field experience portion of the education program.

4. Documentation verifying faculty, including:

a. A medical director who is a licensed physician meeting the applicable requirements for emergency medical services medical directors as outlined in this chapter and rules of the department. The medical director shall have the duty and responsibility of certifying that graduates have successfully completed all phases of the education program and are proficient in basic or advanced life support techniques, as applicable.

b. A program director responsible for the operation,

organization, periodic review, administration, development, and approval of the program.

5. Documentation verifying that the curriculum:

a. Meets the ~~course guides and instructor's lesson plans in the~~ most recent Emergency Medical Technician-Basic National Standard Curricula or the National EMS Education Standards for emergency medical technician programs and Emergency Medical Technician-Paramedic National Standard Curricula or the National EMS Education Standards for paramedic programs, and as approved by the department.

b. Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the department by rule.

~~c. Includes 4 hours of instruction on HIV/AIDS training consistent with the requirements of chapter 381.~~

6. Evidence of sufficient medical and educational equipment to meet emergency medical services training program needs.

(5) Each approved program must notify the department within 30 days after ~~of~~ any change in the professional or employment status of faculty. Each approved program must require its students to pass a comprehensive final written and practical examination evaluating the skills described in the current United States Department of Transportation EMT-Basic or EMT-Paramedic, National Standard Curriculum or the National EMS Education Standards, and as approved by the department. Each approved program must issue a certificate of completion to program graduates within 14 days after ~~of~~ completion.

Section 6. This act shall take effect July 1, 2012.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/CS/SB 470
INTRODUCER:	Budget Subcommittee on Health and Human Services Appropriations, Health Regulation Committee and Senator Jones
SUBJECT:	Chiropractic Medicine
DATE:	January 24, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davlantes	Stovall	HR	**Fav/CS**
2.	Bradford	Hendon	BHA	**Fav/CS**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill revises the regulation of chiropractic medicine in several ways. It:

- Expands eligibility for obtaining a chiropractic medicine faculty certificate;
- Authorizes the Board of Chiropractic Medicine (the Board) to review continuing education courses sponsored by chiropractic colleges before approving them;
- Prohibits approval of chiropractic continuing education courses that pertain to a specific company brand, product line, or service;
- Expands statutory licensure requirements for chiropractic physicians to include passage of Part IV of the National Board of Chiropractic Examiners' (NBCE) certification examination and the NBCE physiotherapy examination;
- Specifies that chiropractic physicians must preserve the identity of funds and property of a patient if the value of the funds and property is greater than $501;
- Specifies that money or other property entrusted to a chiropractic physician by a patient may not exceed the value of $1,500;
- Limits indirect supervision of a certified chiropractic physician's assistant (CCPA) to the supervising physician's address of record;

- Eliminates the 24-month requirement for the CCPA curriculum; and
- Expands and revises the exceptions to ownership and control of a chiropractic practice by persons other than licensed chiropractic physicians.

This bill substantially amends the following sections of the Florida Statutes: 460.406, 460.4062, 460.408, 460.413, 460.4165, and 460.4167.

The bill will have minimal fiscal impact on the Department of Health.

The effective date of this bill is July 1, 2012.

II. Present Situation:

Chiropractic Medicine Faculty Certificates

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

Continuing Chiropractic Education

The Board requires licensed chiropractors to periodically demonstrate their professional competence as a condition of license renewal by completing up to 40 hours of continuing education. Florida Statutes indicate that the Board shall approve continuing education courses that build upon the basic courses required for the practice of chiropractic medicine.[2] To receive Board approval, a continuing education course must meet a number of criteria specified in rule, including the requirement that the course be offered for the purpose of keeping the licensee apprised of advancements and new developments in areas such as general or spinal anatomy; physiology; general or neuro-muscular diagnosis; X-ray technique or interpretation; chemistry; pathology; microbiology; public health; principles or practice of chiropractic medicine; risk management; laboratory diagnosis; nutrition; physiotherapy; phlebotomy; acupuncture; proprietary drug administration; AIDS; and law relating to the practice of chiropractic medicine, the Board, and the regulatory agency under which the Board operates.[3]

National Examination Requirements for Licensure

[1] *See* s. 460.4062(1), F.S.
[2] *See* s. 460.408(1)(b), F.S.
[3] *See* s. 64B2-13.004, F.A.C.

As part of the licensing process for chiropractic medicine, most states require passage of a national examination offered by the NBCE. The NBCE examination consists of four parts. Parts I-III are multiple choice and cover basic and clinical sciences, and Part IV is a practical portion which assesses chiropractic technique, X-ray interpretation and diagnosis, and case management.[4,5] The NBCE also offers a multiple-choice physiotherapy examination. Board rules currently require passage of all four parts of the NBCE examination as well as the physiotherapy examination for licensure of chiropractic physicians, although only Parts I-III of the examination are required in statute.[6]

Grounds for Denial of a Chiropractic Medicine License or Disciplinary Action

Current law and rules of the Board allow chiropractic physicians to accept and hold in trust all unearned fees in the form of cash or property other than cash which are received by a chiropractor prior to the rendering of services or the selling of goods and appliances. Chiropractors who utilize such trust funds are required to maintain trust accounting records and observe certain trust accounting procedures. Failure to preserve the identity of funds and property of a patient constitutes grounds for denial of a license or disciplinary action.[7]

Supervision of Certified Chiropractic Physician's Assistants

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

"Direct supervision" is defined as responsible supervision and requires, except in case of an emergency, the physical presence of the licensed chiropractic physician on the premises for consultation and direction. "Indirect supervision" means responsible supervision and control by the supervising chiropractic physician and requires the "easy availability" or physical presence of the licensed chiropractic physician for consultation and direction of the actions of the CCPA. "Easy availability" means the supervising chiropractic physician must be in a location to enable him or her to be physically present with the CCPA within at least 30 minutes and must be available to the CCPA when needed for consultation and advice either in person or by communication devices such as telephone, two-way radio, medical beeper, or other electronic means.[8]

Under current law, indirect supervision of a CCPA is authorized if the indirect supervision occurs at the address of record or any place of practice of a chiropractic physician to whom he or she is assigned.[9] Indirect supervision is not authorized for CCPAs performing services at a health care clinic licensed under part X of ch. 400, F.S.[10]

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[4] NBCE, *Written Examinations*, available at http://www.nbce.org/written/overview.html (last visited on November 29, 2011).
[5] NBCE, *Practical Examination*, available at http://www.nbce.org/practical/overview.html (last visited on November 29, 2011).
[6] Rule 64B2-11.001(2), F.A.C. and s. 460.406(1)(e), F.S.
[7] *See* s. 460.413(1)(y), F.S., and s. 64B2-14.001, F.A.C.
[8] *See* s. 64B2-18.001(8)-(9), F.A.C.
[9] *See* s. 460.4165(2)(b), F.S.
[10] *See* s. 460.4165(14), F.S.

Education and Training of Certified Chiropractic Physician's Assistants
The DOH is directed under current law to issue certificates of approval for education and training programs for CCPAs which meet Board standards. Any basic program curriculum certified by the Board must cover a period of 24 months and consist of at least 200 didactic classroom hours during the 24 months.[11]

Proprietorship and Control by Persons Other Than Licensed Chiropractic Physicians
Generally only a sole proprietorship, group practice, partnership, or corporation that is wholly owned by one or more chiropractic physicians, or by a chiropractic physician and the spouse, parent, child, or sibling of that chiropractic physician, may employ a chiropractic physician or engage a chiropractic physician as an independent contractor to provide chiropractic services. However, s. 460.4167, F.S., provides for a number of exceptions, which include medical doctors, osteopaths, hospitals, and state-licensed insurers, among others. No exception exists for the surviving spouse, parent, child, or sibling of a deceased chiropractic physician or for a health maintenance organization or prepaid health clinic regulated under ch. 641, F.S., to employ or engage a chiropractic physician.[12]

Current law also prohibits persons who are not chiropractic physicians, entities not wholly owned by one or more chiropractic physicians, and entities not wholly owned by chiropractic physicians and the spouse, parent, child, or sibling of a chiropractic physician, from employing or entering into a contract with a chiropractic physician and thereby exercising control over patient records, decisions relating to office personnel and hours of practice, and policies relating to pricing, credit, refunds, warranties, and advertising. No exceptions to this prohibition are contained in current law.[13]

III. Effect of Proposed Changes:

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

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

Section 3 amends s. 460.406, F.S., to expand licensure requirements for chiropractic physicians to include passage of Part IV of the NBCE certification examination and the NBCE physiotherapy examination.

[11] *See* s. 460.4165(5), F.S.
[12] *See* s. 460.4167(1), F.S.
[13] *See* s. 460.4167(4), F.S.

Section 4 amends s. 460.413, F.S., relating to grounds for disciplinary action against a chiropractic physician, to specify that failing to preserve the identity of funds and property of a patient is grounds for license denial or disciplinary action only when the value of the funds and property is greater than $501. The bill limits the amount of money or other property that may be entrusted to a chiropractor for a specific purpose, including advances for costs and expenses of examination or treatment, to the value of $1,500.

Section 5 amends s. 460.4165, F.S., relating to certified chiropractic physician's assistants, to limit the venues at which CCPAs are allowed to perform chiropractic services under the indirect supervision of a chiropractic physician by removing the chiropractor's place of practice as an authorized venue. A CCPA may continue to perform chiropractic service under indirect supervision at the supervising chiropractor's address of record unless the address or record is a health clinic licensed under part X of ch. 400, F.S.

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

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

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

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

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

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

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

The bill also corrects obsolete statute citations relating to penalties for certain third-degree felonies.

Section 7 provides that the bill takes effect July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Additional chiropractic faculty will be eligible for a chiropractic medicine faculty certificate under this bill.

The performance of chiropractic services by CCPAs will be limited to certain venues, possibly causing a negative fiscal impact on this group.

Additional entities will be able to employ and manage chiropractors.

C. Government Sector Impact:

There will be an increase in workload for the DOH relating to processing additional applications for chiropractic medicine faculty certificates, reviewing the continuing education courses, rulemaking, updating and modifying the Customer Oriented Medical Practitioner Administration System (COMPAS), and responding to complaints filed against CCPAs who continue to perform services at places other than their supervising chiropractor's address or record.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS/CS by Budget Subcommittee on Health and Human Services Appropriations on January 24, 2012:
The CS removes the amendments to section 460.4166, F.S., that would require the registration of Chiropractic Assistants and fees related to the registration.

CS by Health Regulation on December 7, 2011:
The CS requires that applicants for chiropractic licensure in Florida also pass the NBCE physiotherapy examination.

B. Amendments:

None.

547226

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2012	.	
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	.	
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The Committee on Budget Subcommittee on Health and Human Services Appropriations (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 255 - 362.

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

And the title is amended as follows:

Delete lines 24 - 64

and insert:

physician's assistants; amending s.

By the Committee on Health Regulation; and Senator Jones

588-01572-12 2012470c1

A bill to be entitled

An act relating to chiropractic medicine; amending s. 460.4062, F.S.; revising the requirements for obtaining a chiropractic medicine faculty certificate; amending s. 460.408, F.S.; authorizing the Board of Chiropractic Medicine to approve continuing education courses sponsored by chiropractic colleges under certain circumstances; prohibiting the board from approving certain courses in continuing chiropractic education; amending s. 460.406, F.S.; revising requirements for a person who desires to be licensed as a chiropractic physician; amending s. 460.413, F.S.; requiring that a chiropractic physician preserve the identity of funds or property of a patient in excess of a specified amount; limiting the amount that may be advanced to a chiropractic physician for certain costs and expenses; amending s. 460.4165, F.S.; providing that services rendered by a certified chiropractic physician's assistant under indirect supervision may occur only at the supervising chiropractic physician's address of record; deleting the length of time specified for the basic program of education and training for certified chiropractic physician's assistants; amending s. 460.4166, F.S.; authorizing a registered chiropractic assistant to operate therapeutic office equipment; requiring that a registered chiropractic assistant register with the board effective by a specified date and pay a fee for registration under certain circumstances; requiring

588-01572-12 2012470c1

that a registered chiropractic assistant submit an initial application by a specified date, or within 30 days after becoming employed, whichever occurs later; requiring that an applicant specify the place of employment and the names of the supervising chiropractic physicians; requiring that the application be signed by a chiropractic physician who is an owner of the applicant's place of employment; providing an effective date of a registered chiropractic assistant's registration; authorizing certain chiropractic physicians or chiropractic physician's assistants to supervise a registered chiropractic assistant; requiring that a registered chiropractic assistant notify the board of his or her change of employment within a specified time; requiring that a specified chiropractic physician sign the registered chiropractic assistant's notification of change of employment; requiring that the registered chiropractic assistant's employer notify the board when the assistant is no longer employed by that employer; providing eligibility conditions for registering as a registered chiropractic assistant; requiring the biennial renewal of a registered chiropractic assistant's registration and payment of a renewal fee; requiring that the board adopt by rule the forms for certain statutorily required applications and notifications; authorizing the board to accept or require electronically submitted applications, notifications, signatures, or

attestations in lieu of paper applications and actual signatures; requiring the signature of certain forms and notices by specified owners and supervisors under certain conditions; authorizing the board to provide for electronic alternatives to signatures if an application is submitted electronically; amending s. 460.4167, F.S.; authorizing certain sole proprietorships, group practices, partnerships, corporations, limited liability companies, limited partnerships, professional associations, other entities, health care clinics licensed under part X of ch. 400, F.S., health maintenance organizations, or prepaid health clinics to employ a chiropractic physician or engage a chiropractic physician as an independent contractor to provide services authorized by ch. 460, F.S.; authorizing the spouse or adult children of a deceased chiropractic physician to hold, operate, pledge, sell, mortgage, assign, transfer, own, or control the deceased chiropractic physician's ownership interests under certain conditions; authorizing an employer that employs a chiropractic physician to exercise control over the patient records of the employed chiropractic physician, the policies and decisions relating to pricing, credit, refunds, warranties, and advertising, and the decisions relating to office personnel and hours of practice; deleting an obsolete provision; providing an effective date.

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

Section 1. Paragraph (e) of subsection (1) of section 460.4062, Florida Statutes, is amended to read:

460.4062 Chiropractic medicine faculty certificate.—

(1) The department may issue a chiropractic medicine faculty certificate without examination to an individual who remits a nonrefundable application fee, not to exceed $100 as determined by rule of the board, and who demonstrates to the board that he or she meets the following requirements:

(e)1. Performs research or has been offered and has accepted a full-time or part-time faculty appointment to teach in a program of chiropractic medicine at a publicly funded state university or college or at a college of chiropractic located in the state and accredited by the Council on Chiropractic Education; and

2. Provides a certification from the dean of the appointing college acknowledging the appointment.

Section 2. Subsection (1) of section 460.408, Florida Statutes, is amended to read:

460.408 Continuing chiropractic education.—

(1) The board shall require licensees to periodically demonstrate their professional competence as a condition of renewal of a license by completing up to 40 contact classroom hours of continuing education.

(a) Continuing education courses sponsored by chiropractic colleges whose graduates are eligible for examination under any provision of this chapter may ~~shall~~ be approved upon review by the board if all other requirements of board rules setting forth

criteria for course approval are met.

(b) The board shall approve those courses that build upon the basic courses required for the practice of chiropractic medicine, and the board may also approve courses in adjunctive modalities. Courses that consist of instruction in the use, application, prescription, recommendation, or administration of a specific company's brand of products or services are not eligible for approval.

Section 3. Paragraph (e) of subsection (1) of section 460.406, Florida Statutes, is amended to read:

460.406 Licensure by examination.—

(1) Any person desiring to be licensed as a chiropractic physician must apply to the department to take the licensure examination. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee not to exceed $500 plus the actual per applicant cost to the department for purchase of portions of the examination from the National Board of Chiropractic Examiners or a similar national organization, which may be refundable if the applicant is found ineligible to take the examination. The department shall examine each applicant who the board certifies has:

(e) Successfully completed the National Board of Chiropractic Examiners certification examination in parts I, II, ~~and~~ III, and IV, and the physiotherapy examination of the National Board of Chiropractic Examiners, with a score approved by the board.

The board may require an applicant who graduated from an

institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractic, or its equivalent, as determined by the board. The board shall establish by rule a passing score.

Section 4. Paragraph (y) of subsection (1) of section 460.413, Florida Statutes, is amended to read:

460.413 Grounds for disciplinary action; action by board or department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(y) Failing to preserve identity of funds and property of a patient, the value of which is greater than $501. As provided by rule of the board, money or other property entrusted to a chiropractic physician for a specific purpose, including advances for costs and expenses of examination or treatment which may not exceed the value of $1,500, is to be held in trust and must be applied only to that purpose. Money and other property of patients coming into the hands of a chiropractic physician are not subject to counterclaim or setoff for chiropractic physician's fees, and a refusal to account for and deliver over such money and property upon demand shall be deemed a conversion. This is not to preclude the retention of money or other property upon which the chiropractic physician has a valid lien for services or to preclude the payment of agreed fees from the proceeds of transactions for examinations or treatments. Controversies as to the amount of the fees are not grounds for disciplinary proceedings unless the amount demanded is clearly

excessive or extortionate, or the demand is fraudulent. All funds of patients paid to a chiropractic physician, other than advances for costs and expenses, shall be deposited into ~~in~~ one or more identifiable bank accounts maintained in the state in which the chiropractic physician's office is situated, and ~~no~~ funds belonging to the chiropractic physician may not ~~shall~~ be deposited therein except as follows:

1. Funds reasonably sufficient to pay bank charges may be deposited therein.

2. Funds belonging in part to a patient and in part presently or potentially to the physician must be deposited therein, but the portion belonging to the physician may be withdrawn when due unless the right of the physician to receive it is disputed by the patient, in which event the disputed portion may ~~shall~~ not be withdrawn until the dispute is finally resolved.

Every chiropractic physician shall maintain complete records of all funds, securities, and other properties of a patient coming into the possession of the physician and render appropriate accounts to the patient regarding them. In addition, every chiropractic physician shall promptly pay or deliver to the patient, as requested by the patient, the funds, securities, or other properties in the possession of the physician which the patient is entitled to receive.

Section 5. Subsections (2) and (5) of section 460.4165, Florida Statutes, are amended to read:

460.4165 Certified chiropractic physician's assistants.—

(2) PERFORMANCE BY CERTIFIED CHIROPRACTIC PHYSICIAN'S

ASSISTANT.—Notwithstanding any other provision of law, a certified chiropractic physician's assistant may perform chiropractic services in the specialty area or areas for which the certified chiropractic physician's assistant is trained or experienced when such services are rendered under the supervision of a licensed chiropractic physician or group of chiropractic physicians certified by the board. Any certified chiropractic physician's assistant certified under this section to perform services may perform those services only:

(a) In the office of the chiropractic physician to whom the certified chiropractic physician's assistant has been assigned, in which office such physician maintains her or his primary practice;

(b) Under indirect supervision if the indirect supervision occurs at the supervising chiropractic physician's address of record ~~or place of practice~~ required by s. 456.035, other than at a clinic licensed under part X of chapter 400, of the chiropractic physician to whom she or he is assigned as defined by rule of the board;

(c) In a hospital in which the chiropractic physician to whom she or he is assigned is a member of the staff; or

(d) On calls outside ~~of~~ the office of the chiropractic physician to whom she or he is assigned, on the direct order of the chiropractic physician to whom she or he is assigned.

(5) PROGRAM APPROVAL.—The department shall issue certificates of approval for programs for the education and training of certified chiropractic physician's assistants which meet board standards. Any basic program curriculum certified by the board ~~shall cover a period of 24 months. The curriculum~~ must

consist of a curriculum of at least 200 didactic classroom hours ~~during those 24 months~~.

(a) In developing criteria for program approval, the board shall give consideration to, and encourage, the use ~~utilization~~ of equivalency and proficiency testing and other mechanisms whereby full credit is given to trainees for past education and experience in health fields.

(b) The board shall create groups of specialty classifications of training for certified chiropractic physician's assistants. These classifications must ~~shall~~ reflect the training and experience of the certified chiropractic physician's assistant. The certified chiropractic physician's assistant may receive training in one or more such classifications, which shall be shown on the certificate issued.

(c) The board shall adopt and publish standards to ensure that such programs operate in a manner that ~~which~~ does not endanger the health and welfare of the patients who receive services within the scope of the program. The board shall review the quality of the curricula, faculties, and facilities of such programs; issue certificates of approval; and take whatever other action is necessary to determine that the purposes of this section are being met.

Section 6. Subsections (2) and (3) of section 460.4166, Florida Statutes, are amended, and subsections (4), (5), and (6) are added to that section, to read:

460.4166 Registered chiropractic assistants.—

(2) DUTIES.—Under the direct supervision and responsibility of a licensed chiropractic physician or certified chiropractic physician's assistant, a registered chiropractic assistant may:

(a) Perform clinical procedures, which include:

1. Preparing patients for the chiropractic physician's care.

2. Taking vital signs.

3. Observing and reporting patients' signs or symptoms.

(b) Administer basic first aid.

(c) Assist with patient examinations or treatments other than manipulations or adjustments.

(d) Operate therapeutic office equipment.

(e) Collect routine laboratory specimens as directed by the chiropractic physician or certified chiropractic physician's assistant.

(f) Administer nutritional supplements as directed by the chiropractic physician or certified chiropractic physician's assistant.

(g) Perform office procedures required by the chiropractic physician or certified chiropractic physician's assistant under direct supervision of the chiropractic physician or certified chiropractic physician's assistant.

(3) REGISTRATION.—

(a) A registered chiropractic assistant shall register with ~~assistants may be registered by~~ the board for a biennial fee not to exceed $25. Effective April 1, 2013, a person must register with the board as a registered chiropractic assistant if the person performs any duties described in subsection (2), unless the person is otherwise certified or licensed to perform those duties.

(b) A person employed as a registered chiropractic assistant shall submit to the board an initial application for

registration by March 31, 2013, or within 30 days after becoming employed as a registered chiropractic assistant, whichever occurs later, specifying the applicant's place of employment and the names of all chiropractic physicians under whose supervision the applicant performs the duties described in subsection (2). The application for registration must be signed by a chiropractic physician who is an owner of the place of employment specified in the application. Upon the board's receipt of the application, the effective date of the registration is April 1, 2013, or applies retroactively to the applicant's date of employment as a registered chiropractic assistant, whichever occurs later, and the registered chiropractic assistant may be supervised by any licensed chiropractic physician or certified chiropractic physician's assistant who is employed by the registered chiropractic assistant's employer or who is listed on the registration application.

(c) A registered chiropractic assistant, within 30 days after a change of employment, shall notify the board of the new place of employment and the names of all chiropractic physicians under whose supervision the registered chiropractic assistant performs duties described in subsection (2) at the new place of employment. The notification must be signed by a chiropractic physician who is an owner of the new place of employment. Upon the board's receipt of the notification, the registered chiropractic assistant may be supervised by any licensed chiropractic physician or certified chiropractic physician's assistant who is employed by the registered chiropractic assistant's new employer or who is listed on the notification.

(d) Within 30 days after a registered chiropractic assistant is no longer employed at his or her place of employment as registered with the board, the registered chiropractic assistant's employer as registered with the board shall notify the board that the registered chiropractic assistant is no longer employed by that employer.

(e) An employee who performs none of the duties described in subsection (2) is not eligible to register under this subsection.

(4) REGISTERED CHIROPRACTIC ASSISTANT REGISTRATION RENEWAL.—

(a) A registered chiropractic assistant's registration must be renewed biennially. Each renewal must include:

1. A renewal fee as set by the board, not to exceed $25.

2. The registered chiropractic assistant's current place of employment and the names of all chiropractic physicians under whose supervision the applicant performs duties described in subsection (2). The application for registration renewal must be signed by a chiropractic physician who is an owner of the place of employment specified in the application.

(b) Upon registration renewal, the registered chiropractic assistant may be supervised by any licensed chiropractic physician or certified chiropractic physician's assistant who is employed by the registered chiropractic assistant's employer or who is listed on the registration renewal.

(5) APPLICATION AND NOTIFICATION FORMS.—The board shall prescribe by rule the forms for the registration application, notification, and registration renewal that are required under subsections (3) and (4). The board may accept or may require

electronically submitted registration applications, notifications, registration renewals, attestations, or signatures in lieu of paper applications, notifications, renewals, or attestations or actual signatures.

(6) SIGNATURE REQUIREMENTS.—If a registered chiropractic assistant is employed by an entity that is not owned in whole or in part by a licensed chiropractic physician under s. 460.4167, the documents requiring signatures under this section must be signed by a person having an ownership interest in the entity that employs the assistant and by the licensed chiropractic physician who supervises the assistant. In lieu of written signatures, the board may provide for electronic alternatives to signatures if an application is submitted electronically, in which instance all other requirements in this section apply.

Section 7. Section 460.4167, Florida Statutes, is amended to read:

460.4167 Proprietorship by persons other than licensed chiropractic physicians.—

(1) A ~~No~~ person ~~other than a sole proprietorship, group practice, partnership, or corporation that is wholly owned by one or more chiropractic physicians licensed under this chapter or by a chiropractic physician licensed under this chapter and the spouse, parent, child, or sibling of that chiropractic physician~~ may not employ a chiropractic physician licensed under this chapter or engage a chiropractic physician licensed under this chapter as an independent contractor to provide services that chiropractic physicians are authorized to offer ~~by this chapter to be offered by a chiropractic physician licensed~~ under this chapter, unless the person is any of the following~~, except~~

~~for~~:

(a) A sole proprietorship, group practice, partnership, corporation, limited liability company, limited partnership, professional association, or any other entity that is wholly owned by:

1. One or more chiropractic physicians licensed under this chapter;

2. A chiropractic physician licensed under this chapter and the spouse or surviving spouse, parent, child, or sibling of the chiropractic physician; or

3. A trust whose trustees are chiropractic physicians licensed under this chapter and the spouse, parent, child, or sibling of a chiropractic physician.

If the chiropractic physician described in subparagraph (a)2. dies, notwithstanding part X of chapter 400, the surviving spouse or adult children may hold, operate, pledge, sell, mortgage, assign, transfer, own, or control the chiropractic physician's ownership interests for so long as the surviving spouse or adult children remain the sole proprietors of the chiropractic practice.

(b) ~~(a)~~ A sole proprietorship, group practice, partnership, ~~or~~ corporation, limited liability company, limited partnership, professional association, or any other entity that is wholly owned by a physician or physicians licensed under this chapter, chapter 458, chapter 459, or chapter 461.

(c) ~~(b)~~ An entity ~~Entities~~ that is wholly ~~are~~ owned, directly or indirectly, by an entity licensed or registered by the state under chapter 395.

(d) ~~(c)~~ A clinical facility that is ~~facilities~~ affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(e) ~~(d)~~ A public or private university or college.

(f) ~~(e)~~ An entity wholly owned and operated by an organization that is exempt from federal taxation under s. 501(c)(3) or (4) of the Internal Revenue Code, a ~~any~~ community college or university clinic, or an ~~and any~~ entity owned or operated by the Federal Government or by state government, including any agency, county, municipality, or other political subdivision thereof.

(g) ~~(f)~~ An entity owned by a corporation the stock of which is publicly traded.

(h) ~~(g)~~ A clinic licensed under part X of chapter 400 which ~~that~~ provides chiropractic services by a chiropractic physician licensed under this chapter and other health care services by physicians licensed under chapter 458 or~~,~~ chapter 459, ~~or chapter 460,~~ the medical director of which is licensed under chapter 458 or chapter 459.

(i) ~~(h)~~ A state-licensed insurer.

(j) A health maintenance organization or prepaid health clinic regulated under chapter 641.

(2) A ~~No~~ person other than a chiropractic physician licensed under this chapter may not ~~shall~~ direct, control, or interfere with a chiropractic physician's clinical judgment regarding the medical necessity of chiropractic treatment. For purposes of this subsection, a chiropractic physician's clinical judgment does not apply to chiropractic services that are

contractually excluded, the application of alternative services that may be appropriate given the chiropractic physician's prescribed course of treatment, or determinations that compare ~~comparing~~ contractual provisions and scope of coverage with a chiropractic physician's prescribed treatment on behalf of a covered person by an insurer, health maintenance organization, or prepaid limited health service organization.

(3) Any lease agreement, rental agreement, or other arrangement between a person other than a licensed chiropractic physician and a chiropractic physician whereby the person other than a licensed chiropractic physician provides the chiropractic physician with chiropractic equipment or chiropractic materials must ~~shall~~ contain a provision whereby the chiropractic physician expressly maintains complete care, custody, and control of the equipment or practice.

(4) The purpose of this section is to prevent a person other than the ~~a~~ licensed chiropractic physician from influencing or otherwise interfering with the exercise of the ~~a~~ chiropractic physician's independent professional judgment. In addition to the acts specified in subsection (2) ~~(1)~~, a person or entity other than an employer or entity authorized in subsection (1) ~~a licensed chiropractic physician and any entity other than a sole proprietorship, group practice, partnership, or corporation that is wholly owned by one or more chiropractic physicians licensed under this chapter or by a chiropractic physician licensed under this chapter and the spouse, parent, child, or sibling of that physician,~~ may not employ or engage a chiropractic physician licensed under this chapter. A person or entity may not ~~or~~ enter into a contract or arrangement with a

chiropractic physician pursuant to which such ~~unlicensed~~ person or ~~such~~ entity exercises control over the following:

(a) The selection of a course of treatment for a patient, the procedures or materials to be used as part of the ~~such~~ course of treatment, and the manner in which the ~~such~~ course of treatment is carried out by the chiropractic physician ~~licensee~~;

(b) The patient records of the chiropractic physician ~~a chiropractor~~;

(c) The policies and decisions relating to pricing, credit, refunds, warranties, and advertising; or

(d) The decisions relating to office personnel and hours of practice.

However, a person or entity that is authorized to employ a chiropractic physician under subsection (1) may exercise control over the patient records of the employed chiropractic physician; the policies and decisions relating to pricing, credit, refunds, warranties, and advertising; and the decisions relating to office personnel and hours of practice.

(5) Any person who violates this section commits a felony of the third degree, punishable as provided in s. 775.082 ~~s. 775.081~~, s. 775.083, or s. 775.084 ~~s. 775.035~~.

(6) Any contract or arrangement entered into or undertaken in violation of this section is ~~shall be~~ void as contrary to public policy. ~~This section applies to contracts entered into or renewed on or after July 1, 2008.~~

Section 8. This act shall take effect July 1, 2012.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 414
INTRODUCER:	Health Regulation Committee and Senator Negron
SUBJECT:	Osteopathic Physicians
DATE:	January 19, 2012 REVISED:

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

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill revises requirements for licensure to practice osteopathic medicine in Florida for physicians who have not actively practiced osteopathic medicine for more than the previous two years and for new, unlicensed physicians who completed internship, residency, or fellowship more than two years ago. Any such physician whose present ability and fitness to practice osteopathic medicine has been adversely affected by the interruption of his or her active practice of osteopathic medicine, as determined by the Board of Osteopathic Medicine (the board), may, at the board's discretion, be denied licensure in Florida, granted a license with restrictions, or granted full licensure upon fulfillment of certain conditions.

The bill removes the requirement that a person desiring to be registered to practice as a resident physician, intern, or fellow must pass all parts of the examination conducted by the National Board of Osteopathic Medical Examiners and complete one year of residency, and deletes obsolete and redundant nomenclature.

The fiscal impact of this bill is insignificant.

This bill substantially amends ss. 459.0055 and 459.021, F.S.

II. Present Situation:

General Licensure Requirements

Osteopathic physicians are licensed to practice under ch. 459, F.S. Licensure requirements for osteopathic physicians are set forth in s. 459.0055, F.S. An applicant must:

- Submit the appropriate application form and fees;
- Be at least 21 years of age and of good moral character;
- Complete at least 3 years of pre-professional post-secondary education;
- Not have committed or be under investigation for any violation of ch. 459, F.S., unless the board determines the violation does not adversely affect the applicant's fitness and ability to practice osteopathic medicine;
- Not have had a medical license revoked, suspended, or otherwise acted against by the licensing authority of any jurisdiction unless the board determines the underlying action does not adversely affect the applicants current ability and fitness to practice osteopathic medicine;
- Have received satisfactory evaluations from his or her residency or fellowship training programs unless poorer evaluations are deemed to not adversely affect the applicant's current ability and fitness to practice osteopathic medicine;
- Undergo a background check with the Department of Health (the department);
- Have graduated from a medical college approved by the American Osteopathic Association;
- If graduated from an osteopathic medical school after 1948, have completed at least 1 year of residency training in an approved hospital; and
- Pass all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board no more than five years before applying for licensure in Florida.

Reciprocity does exist for an osteopathic physician licensed in another state if the physician's license was initially issued within five years of passing an examination conducted by the National Board of Medical Examiners or its equivalent. This reciprocity does not extend to physicians who have been out of practice for more than two years, unless this period of inactivity is not considered to have adversely affected the physician's fitness and ability to practice osteopathic medicine.

If an applicant has committed a violation of any part of this chapter or has a license suspended, revoked, or otherwise acted against by a licensing authority in a different jurisdiction, the board may choose to provide that applicant a restricted osteopathic medical license.

Special Licenses

Limited licenses may be issued to osteopathic physicians who do not hold an active license to practice osteopathic medicine in Florida but have been licensed in any jurisdiction or U.S. territory in good standing for at least 10 years. Limited licenses may only be used to practice for public agencies or institutions or 501(c)(3) nonprofit organizations in medically underserved areas of the state.[1]

[1] Section 459.0075, F.S.

Temporary certificates may be issued to osteopathic physicians who are currently licensed in any jurisdiction or who have practiced as a military physician for at least 10 years and have been honorably discharged. Temporary certificates may be used to practice for county health departments, correctional facilities, Veterans' Affairs clinics, or other department-approved institution that serves a population of critical need or in underserved areas. Temporary certificates may also be used to practice for a limited time in an area of physician-specialty, demographic, or geographic need as determined by the State Surgeon General.[2]

Osteopathic faculty certificates may be issued without examination to osteopathic physicians who are licensed in other states and otherwise meet the standards for licensure described under s. 459.0055, F.S. A faculty certificate may be used to practice medicine only in conjunction with the holder's teaching duties at an accredited school of osteopathic medicine and its affiliated teaching hospitals and clinics.[3]

Renewal of Licenses and Certificates

Osteopathic medical practice licenses and certificates are renewed biennially. Applicants for renewal must submit the appropriate paperwork and fee, complete a physician workforce survey provided by the department, submit to a background check, and complete a certain number of hours of continuing education.[4]

Educational Pipeline for Osteopathic Physicians

The training of osteopathic physicians begins with a four-year bachelor's degree, followed by four years of medical school. A potential osteopathic physician must also pass a series of examinations developed and administered by the National Board of Osteopathic Medical Examiners. Level 1, and Level 2-CE, and Level 2-PE must be passed during medical school; Level 3 may only be taken after graduation from medical school.[5] Passage of all three levels of the National Board of Osteopathic Medical Examiners examination or a similar examination is required for licensure of osteopathic physicians in all states.

Terminology for Medical Residents

After graduation from medical school, new physicians enter residency programs for further practical training in the various specialties of medicine. Physicians must complete at least one year of residency training before they may be licensed in Florida.[6] Residency programs range in length from three to seven years depending on the educational institution and medical specialty.

[2] Section 459.0076, F.S.
[3] Section 459.0077, F.S.
[4] Section 459.008, F.S.
[5] National Board of Osteopathic Medical Examiners, *COMLEX-USA Bulletin of Information 2011-2012*, available at http://www.nbome.org/docs/comlexBOI.pdf (last visited on November 2, 2011).
[6] Section 459.0055(1)(l), F.S., concerning osteopathic physicians, and s. 458.311(1)(f), F.S., concerning allopathic physicians.

A resident in his or her first year of training is called an intern. A resident in a training year other than the first is simply called a resident. After completing residency, a physician can enter a fellowship program which provides further specialized training in a particular area. Such physicians are called fellows.

Another name for a resident is a house physician. Assistant resident physicians do not exist.

III. Effect of Proposed Changes:

Section 1 amends s. 459.0055, F.S., relating to general licensure requirements for osteopathic physicians. Licensure provisions related to reciprocity for osteopathic physicians licensed in other states is moved from subsection (2) to subsection (1).

The bill grants the board licensure options for:

- Osteopathic physicians licensed in other states who have not actively practiced medicine for more than the previous two years, or
- New, unlicensed physicians who completed internship, residency, or fellowship more than two years ago;
- And physicians whose present ability and fitness to practice osteopathic medicine has been adversely affected by the interruption of their active practice of osteopathic medicine, as determined by the board.

Such physicians may be denied licensure in Florida; be granted a license with restrictions such as the requirement to practice under the supervision of another physician; or be fully licensed upon completion of reasonable conditions, such as remedial training as prescribed by the board. Currently, an osteopathic physician licensed in another state may only be granted a full license, notwithstanding a break in practice for two or more years if the board determines the interruption has not adversely affected the osteopathic physician's ability and fitness to practice osteopathic medicine.

Section 2 amends s. 459.021, F.S., to remove obsolete and redundant language concerning nomenclature for physicians in training. It also removes language requiring persons desiring to be registered to practice as resident physicians, interns, or fellows to have passed all parts of the examination conducted by the National Board of Osteopathic Medical Examiners and to have completed 1 year of residency.

Section 3 provides the bill will take effect on July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The department indicates it may experience a slight increase in workload by evaluating the competencies of certain physicians. However, such evaluations will help improve healthcare in the state by ensuring that all licensed osteopathic physicians are fit to practice independently, and the fiscal impact will be negligible.[7]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Health Regulation on December 7, 2011:
The CS provides more general guidelines to the board concerning the evaluation for licensure of osteopathic physicians who have been out of active practice for more than two years. Any physician whose present ability and fitness to practice osteopathic medicine has been adversely affected by the interruption of his or her active practice of osteopathic medicine, as determined by the board, may, at the board's discretion, be denied licensure in Florida, granted a license with restrictions, or granted full licensure

[7] Department of Health, *2012 Bill Analysis, Economic Statement, and Fiscal Note for SB 414*. A copy of this analysis is on file with the Senate Health Regulation Committee.

upon fulfillment of certain conditions. This replaces language in SB 414 which stated that the board could only deny licensure or grant restricted licensure to those osteopathic physicians who the board determined may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking.

B. Amendments:

None.

By the Committee on Health Regulation; and Senator Negron

588-01571-12 2012414c1

A bill to be entitled

An act relating to osteopathic physicians; amending s. 459.0055, F.S.; revising the requirements for licensure or certification as an osteopathic physician in this state; amending s. 459.021, F.S.; revising provisions relating to registration of physicians, interns, and fellows; providing an effective date.

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

Section 1. Paragraph (m) of subsection (1) and subsection (2) of section 459.0055, Florida Statutes, are amended to read:

459.0055 General licensure requirements.—

(1) Except as otherwise provided herein, any person desiring to be licensed or certified as an osteopathic physician pursuant to this chapter shall:

(m) Demonstrate that she or he has obtained a passing score, as established by rule of the board, on all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board no more than 5 years before making application in this state or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than 5 years after the applicant obtained a passing score on the examination conducted by the National Board of Osteopathic Medical Examiners or other substantially similar examination approved by the board.

(2) If the applicant holds a valid active license in another state and it has been more than 2 years since the active

588-01571-12 2012414c1

practice of osteopathic medicine, or if an applicant does not hold a valid active license to practice osteopathic medicine in another state and it has been more than 2 years since completion of a resident internship, residency, or fellowship, and the board determines that the interruption of the osteopathic physician's practice of osteopathic medicine has adversely affected the osteopathic physician's present ability and fitness to practice osteopathic medicine, the board may:

(a) Deny the application;

(b) Issue a license having reasonable restrictions or conditions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

(c) Issue a license upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training. ~~For an applicant holding a valid active license in another state, he or she shall submit evidence of the active licensed practice of medicine in another jurisdiction in which initial licensure must have occurred no more than 5 years after the applicant obtained a passing score on the examination conducted by the National Board of Medical Examiners or other substantially similar examination approved by the board; however, such practice of osteopathic medicine may have been interrupted for a period totaling no more than 2 years or for a longer period if the board determines that the interruption of the osteopathic physician's practice of osteopathic medicine for such longer period has not adversely affected the osteopathic~~

~~physician's present ability and fitness to practice osteopathic medicine.~~

Section 2. Subsections (1), (3), (4), and (6) of section 459.021, Florida Statutes, are amended to read:

459.021 Registration of resident physicians, interns, and fellows; list of hospital employees; penalty.—

(1) Any person who holds a degree of Doctor of Osteopathic Medicine from a college of osteopathic medicine recognized and approved by the American Osteopathic Association who desires to practice as a resident physician, ~~assistant resident physician, house physician,~~ intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, ~~assistant resident physician, house physician,~~ intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(45) or s. 395.805(2), who does not hold an active license issued under this chapter shall apply to the department to be registered, on an application provided by the department, before commencing such a training program and shall remit a fee not to exceed $300 as set by the board.

(3) Every hospital or teaching hospital having employed or contracted with or utilized the services of a person who holds a degree of Doctor of Osteopathic Medicine from a college of osteopathic medicine recognized and approved by the American Osteopathic Association as a resident physician, ~~assistant resident physician, house physician,~~ intern, or fellow in fellowship training registered under this section shall designate a person who shall furnish, on dates designated by the board, in consultation with the department, to the department a

list of all such persons who have served in such hospital during the preceding 6-month period. The chief executive officer of each such hospital shall provide the executive director of the board with the name, title, and address of the person responsible for filing such reports.

(4) The registration may be revoked or the department may refuse to issue any registration for any cause which would be a ground for its revocation or refusal to issue a license to practice osteopathic medicine, as well as on the following grounds:

(a) Omission of the name of an intern, resident physician, ~~assistant resident physician, house physician,~~ or fellow in fellowship training from the list of employees required by subsection (3) to be furnished to the department by the hospital or teaching hospital served by the employee.

(b) Practicing osteopathic medicine outside of a bona fide hospital training program.

(6) Any person desiring registration pursuant to this section shall meet all the requirements of s. 459.0055, except paragraphs (1)(l) and (m).

Section 3. This act shall take effect July 1, 2012.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 730
INTRODUCER:	Health Regulation Committee and Senator Flores and Others
SUBJECT:	Medicaid Managed Care Plans
DATE:	January 20, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Stovall	HR	**Fav/CS**
2.	Brown	Hendon	BHA	**Favorable**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill changes the statewide Medicaid managed care program (the managed medical assistance program and the long-term care managed care program) with respect to the role that Medicare Advantage plans will play in the program, for recipients who are dually eligible for Medicaid and Medicare. The bill requires the Agency for Health Care Administration (AHCA) to establish a per-member, per-month payment for dually eligible individuals enrolled in any Medicare Advantage coordinated care plan, not just in a Medicare Advantage special needs plan.

The definition of "eligible plan" for the statewide Medicaid managed care program and various other statutory references to eligible plans in the program are amended to include additional Medicare Advantage organizations and plans, for purposes of providing coverage to individuals who are dually eligible for Medicaid and Medicare and who are to be enrolled in the managed medical assistance program and the long-term care managed care program.

The bill exempts a Medicare Advantage coordinated care plan from the procurement requirements and regional plan limits of the new Medicaid managed medical assistance program, if the plan's Medicaid enrollees in the region consist exclusively of its current Medicare enrollees who are dually eligible for Medicaid and Medicare. Also, the bill requires the AHCA to

automatically enroll Medicaid managed medical assistance program recipients who have not voluntarily selected a plan, who are dually eligible, and who are currently receiving Medicare services from a Medicare Advantage coordinated care plan to that Medicare Advantage plan, if the plan is currently under contract with the AHCA.

The bill modifies the existing exemption from the procurement requirements of the Medicaid long-term care managed care program for Medicare Advantage plans serving dually eligible recipients. The bill specifies that the exemption from the procurement requirements applies only if the Medicare Advantage plan's Medicaid enrollees consist exclusively of its current Medicare enrollees.

The bill reduces the penalty imposed on certain managed care plans that leave a region before the end of the term of their contract with the AHCA.

The bill has no direct fiscal impact on government.

This bill substantially amends the following sections of the Florida Statutes: 409.9122, 409.962, 409.967, 409.974, 409.977, 409.981, and 409.984.

The bill has an effective date of July 1, 2012.

II. Present Situation:

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The AHCA is responsible for administering the Medicaid program. Medicaid serves approximately 3.19 million people in Florida, with over half of those being children and adolescents 20 years of age or younger. Estimated Medicaid expenditures for FY 2011-2012 are approximately $20.3 billion.

Medicaid Managed Care

Part III of ch. 409, F.S., provides the statutory requirements for the Florida Medicaid program. Sections 409.9121 – 409.9124, F.S., contain provisions relating to managed care in Medicaid.

In 1993, the Legislature passed legislation declaring its intent that the Medicaid program require, to the maximum extent practicable and permitted by federal law, that all Medicaid recipients be enrolled in a managed care program.[1] This intent language was codified in s. 409.9121, F.S., and has remained in effect and unchanged since 1993. Section 409.9122, F.S., which was also created in 1993, set Florida on the path of mandatory enrollment of Medicaid recipients in managed care by providing for the statewide expansion of the primary care case management program known as MediPass and for the growth of health maintenance organizations and prepaid health plans for Medicaid recipients. Section 409.9122, F.S., has been amended almost every year since 1993 to expand the role of managed care in Medicaid as managed care has evolved.

[1] *See* s. 50 of ch. 93-129, L.O.F.

In 2005, the Legislature directed the AHCA to seek federal Medicaid waivers pursuant to s. 1115 of the Social Security Act to create a Medicaid managed care pilot program in five counties in the State. Under the pilot program, most Medicaid recipients have been moved from Medicaid fee-for-service and the MediPass program into capitated managed care systems. As of December 15, 2011, the pilot program waiver was extended for three years, through June 30, 2014. This coincides with implementation of the new statewide Medicaid managed care program established in 2011 and codified in pt. IV of ch. 409, F.S. (s. 409.961 – 409.9841, F.S.).[2]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed medical assistance program. The law directs the AHCA to begin implementation of the long-term care managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. By January 1, 2013, the AHCA must begin implementation of the managed medical assistance program, with full implementation in all regions of the State by October 1, 2014.

The AHCA is required to separately procure long-term care managed care plans and managed medical assistance plans in each of the 11 regions of the state, which coincide with the existing Medicaid areas. The AHCA is required to select a limited number of eligible plans to participate in the program using Invitations to Negotiate. Each Medicaid recipient must have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

Section 409.967(4)(h)1., F.S., requires plans that reduce enrollment levels or withdraw from an area of operation before a contract term is over to reimburse the AHCA for the cost of enrollment changes and other transition activities. If more than one plan leaves an area, the plans are required to split the cost proportionate to their enrollment. In addition to payment of costs, departing provider services network plans must pay a penalty of up to 3 months' payment and departing health maintenance organization plans must pay a penalty of 25 percent of the minimum surplus which they are required to maintain under s. 641.225(1), F.S.

Dual Eligibles

Dual eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage. Medicare covers their acute care services, while Medicaid covers Medicare premiums and cost sharing, and—for those below certain income and asset thresholds—long-term care services and, until 2006, prescription drugs, among other services. The term "dual eligible" encompasses all Medicare beneficiaries who receive Medicaid assistance, including those who receive the full range of Medicaid benefits and those who receive assistance only with Medicare premiums or cost sharing.

Currently, dual eligibles cannot be mandatorily assigned to managed care. The AHCA is seeking authority to mandatorily assign dual eligibles to long-term care managed care plans and managed medical assistance plans.

[2] *See* ch. 2011-134, L.O.F.

Medicare Advantage Plans

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services.

Medicare has four different parts that cover specific services.

- *Part A* (Hospital Insurance) helps cover inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care.
- *Part B* (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps cover some preventive services that help people maintain their health and keep certain illnesses from getting worse.
- *Part C* (Medicare Advantage Plans) covers Part A, Part B, and usually Part D services provided by Medicare-approved private insurance companies.
- *Part D* (Prescription Drug Coverage) helps cover the cost of prescription drugs through Medicare-approved private insurance companies.

The Balanced Budget Act of 1997 established a new Part C of the Medicare program, known then as the Medicare+Choice program, effective January 1999. The act authorized the CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including coordinated care plans, Medicare Medical Savings Account plans, private-fee-for-service plans, and Religious Fraternal Benefit plans. These health plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the original Medicare program.

The Medicare+Choice program in Part C of Medicare was renamed the Medicare Advantage Program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which was enacted in December 2003. This act updated and improved the choice of plans for beneficiaries under Part C. Beneficiaries may now choose from additional plan options, including regional preferred provider organization plans and special needs plans. The act also established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow (and, for organizations offering coordinated care plans, require) most Medicare Advantage plans to offer prescription drug coverage.

Coordinated care plans are plans that include a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by the CMS. They may include mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. Coordinated care plans include plans offered by any of the following:

- Health maintenance organizations (HMOs);
- Provider-sponsored organizations (PSOs);

- Regional or local preferred provider organizations (PPOs);
- Other network plans, except for private-fee-for-service plans; and
- Specialized Medicare Advantage plans for special needs individuals, which include any type of coordinated care plan that exclusively enrolls special needs individuals.[3] Special needs individuals are Medicare Advantage eligible individuals who are institutionalized, have severe or disabling chronic conditions, or qualify both for Medicare and Medicaid benefits (dual eligibles).[4]

Specialized Medicare Advantage plans for special needs individuals must provide Part D benefits. They must be designated by the CMS as meeting the requirements of a Medicare Advantage special needs plan as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.

Medicare Advantage organizations seeking to offer a special needs plan serving beneficiaries eligible for both Medicare and Medicaid must have a contract with the State Medicaid agency (the AHCA).[5] Medicare Advantage plans wishing to offer a special needs plan are required to meet additional requirements set forth by federal law, including approval by the National Commission on Quality Assurance, effective January 1, 2012.

The Medicare Advantage program also provides for a "*fully integrated* dual eligible special needs plan." The fully integrated plan is a CMS-approved Medicare Advantage/Prescription Drug dual eligible special needs plan that:

- Enrolls special needs individuals entitled to medical assistance under Medicaid;
- Provides dual eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;
- Has a capitated contract with a State Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services;
- Coordinates the delivery of covered Medicare and Medicaid health and long-term care services using aligned care management and specialty network methods for high-risk beneficiaries; and
- Employs policies and procedures approved by the CMS and the State to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement.[6]

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[3] 42 C.F.R. part 422.4, Types of MA plans. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6458b5363e3fed66ddaf309b5baa0b31&rgn=div8&view=text&node=42:3.0.1.1.9.1.5.3&idno=42> (Last visited on January 17, 2012).

[4] 42 C.F.R. part 422.2, Definitions. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=92c8e79ce6a6a52e4b60a4251b9a8745;rgn=div8;view=text;node=42%3A3.0.1.1.9.1.5.2;idno=42;cc=ecfr> (Last visited on January 17, 2012).

[5] 42 C.F.R. part 422.107, Special needs plans and dual-eligibles: Contract with State Medicaid Agency. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=92c8e79ce6a6a52e4b60a4251b9a8745;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr#42:3.0.1.1.9.3.5.8> (Last visited on January 17, 2012).

[6] 42 C.F.R. part 422.2, Definitions. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=92c8e79ce6a6a52e4b60a4251b9a8745;rgn=div8;view=text;node=42%3A3.0.1.1.9.1.5.2;idno=42;cc=ecfr> (Last visited on January 17, 2012).

Health Maintenance Organization Minimum Surplus Requirement

Subsection 641.225(1), F.S., requires each health maintenance organization to maintain at all times a minimum surplus in an amount that is the greater of $1,500,000, 10 percent of total liabilities, or 2 percent of total annualized premium. The surplus account requirement is not specific to a certain line of business. Companies that operate or own multiple plans are only required to hold one surplus account.

III. Effect of Proposed Changes:

Section 1 amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment, to require, rather than to authorize, the AHCA to establish a per-member, per-month payment for enrollees of a Medicare Advantage coordinated care plan who are also eligible for Medicaid. The existing statutory provision applies only to members of Medicare Advantage special needs plans who are also eligible for Medicaid. The AHCA currently contracts with 12 Medicare Advantage special needs plans and has established a per-member, per-month payment. By using the term Medicare Advantage coordinated care plans, plans other than Medicare Advantage special needs plans would receive a per-member, per-month payment for enrollees who are dual eligibles. This will have an impact on enrollment levels of the existing contractees.

Section 2 amends s. 409.962, F.S., which provides definitions for the recently enacted Medicaid managed care program, to modify the definition of "eligible plan." The bill clarifies that, for purposes of dual eligibles, the term "eligible plan" includes all Medicare Advantage coordinated care plans. The term is also expanded to include dual eligibles enrolled in the managed medical assistance program, not just enrollees in the long-term care managed care program.

According to the AHCA,[7] there are 87,000 Medicaid recipients residing in a nursing home or participating in a waiver program who will be required to participate in the long-term care managed care program. Of these, 82,000 are dual eligibles who are eligible for full Medicaid services and Medicare services. The AHCA does not currently know the number of these individuals who are enrolled in Medicare Advantage plans or the Medicare Advantage plans in which they are enrolled. In order to implement this provision, the AHCA may need to obtain information from Medicare Advantage plans and may need to make systems changes.

There will be 5,000 who are not dual eligibles who will be eligible for both the long-term care managed care program and the managed medical assistance program. These individuals would not qualify for enrollment in a Medicare Advantage plan.

Section 3 amends s. 409.967, F.S., relating to managed care plan accountability, to clarify that, for plans, other than provider services networks, only the *departing* plans must pay the penalty of 25 percent of the minimum surplus required under s. 641.225(1), F.S. The bill also reduces the penalty on departing plans, other than provider services networks, to 25 percent of the minimum surplus which is attributable to the provision of coverage to Medicaid enrollees, not all plan enrollees. This change may potentially reduce the payment a departing plan must make.

[7] *See* Agency for Health Care Administration 2012 Bill Analysis and Economic Impact Statement for SB 730 – on file with the Health Regulation Committee.

Section 4 amends s. 409.974, F.S., relating to eligibility of plans for participation in the Medicaid managed medical assistance program, to exempt a Medicare Advantage coordinated care plan from the procurement requirements or regional plan limits applicable to other managed care plans, if the Medicare Advantage coordinated care plan's Medicaid enrollees in the region consist exclusively of its current Medicare enrollees who are dually eligible. Participation by such plans would be pursuant to a contract with the AHCA. If a plan's Medicaid enrollees are not exclusively its current Medicare enrollees who are dually eligible, the plan must meet all procurement requirements. The bill corrects an incorrect cross-reference.

If Medicare Advantage plans are allowed to become Medicaid managed medical assistance plans and are not subject to procurement requirements, the AHCA will need to develop an open application document and process in addition to the competitive procurement documents and process specified in current law. The application would be necessary to ensure that Medicare Advantage plans meet or have the ability to meet all statutorily required and agency-defined contract requirements.

Section 5 amends s. 409.977, F.S., relating to enrollment of Medicaid managed medical assistance program recipients into managed care plans, to specify that, if a Medicaid recipient has not voluntarily selected a plan, is a dual eligible, and is currently receiving Medicare services from a Medicare Advantage coordinated care plan, the AHCA must automatically enroll the recipient in that plan for Medicaid services, if the plan is under contract with the AHCA.

The dual-eligible population makes up a large portion of the long-term-care population available for enrollment in Medicaid health plans. Under the provisions of this section, a health plan selected by the AHCA for the managed medical assistance program that is not also a Medicare Advantage plan may not have as many enrollments as a plan that does have a Medicare Advantage plan. Existing Medicare Advantage plans would have the advantage in enrolling dual eligibles for Medicaid services.

Section 6 amends s. 409.981, F.S., relating to eligibility of long-term care plans for participation in the Medicaid long-term care managed care program, to expand the list of Medicare Advantage plans to include all the Medicare Advantage coordinated care plans. The law currently includes only Medicare Advantage preferred provider organizations, Medicare Advantage provider-sponsored organizations, and Medicare Advantage special needs plans. The bill also limits the existing statutory exemption for such plans from the procurement requirements to plans whose Medicaid enrollees consist exclusively of its current Medicare enrollees who are dually eligible.

Section 7 amends s. 409.984, F.S., relating to enrollment of Medicaid recipients into long-term care managed care plans, to expand the list of Medicare Advantage plans to include all the Medicare Advantage coordinated care plans. The law currently includes only Medicare Advantage preferred provider organizations, Medicare Advantage provider-sponsored organizations, and Medicare Advantage special needs plans. This will potentially increase the number of plans available and potentially reduce enrollment in each plan.

Section 8 provides an effective date of July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has no discernable fiscal impact on government. The number of persons enrolled, the scope and extent of services, and the costs associated with the services will remain the same under the changes contained in the bill.[8]

VI. Technical Deficiencies:

The term "Medicare Advantage coordinated care plan" is the federal Medicare term that encompasses a variety of plans that are offered by various organizations. It may be sufficient to refer to "Medicare Advantage coordinated care plans" as section 1 of the bill does, rather than listing all the types of organizations and plans within that broader category throughout the bill.

VII. Related Issues:

Section 1 of the bill requires the AHCA to establish a per-member, per-month payment for enrollees of a Medicare Advantage coordinated care plan who are also eligible for Medicaid. There are currently Medicare Advantage special needs plans that have entered into Coordination of Benefits Agreements with the AHCA. Under these agreements, the plan coordinates care for its members and the AHCA pays any cost sharing. Cost-sharing includes deductibles,

[8] *Id.*

coinsurance, and co-payments, but does not include any premiums. The AHCA does not pay a per-member, per-month payment to the plans that have a Coordination of Benefits Agreement with the AHCA.

Implementation of the requirement on lines 86-87 to split the minimum surplus requirement for health maintenance organizations into Medicaid and non-Medicaid business will be dependent on the ability of the AHCA to obtain the necessary data to develop a methodology for calculating the penalty on only the Medicaid-related surplus requirement. The AHCA has indicated that it is currently unable to identify what portion of the surplus requirement is related to Medicaid recipients.[9]

VIII. Additional Information:

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

CS by Health Regulation on January 19, 2012:
The CS exempts Medicare Advantage plans from the procurement requirements for the managed medical assistance program and the long-term care managed care program only if their Medicaid enrollees consist exclusively of their current Medicare enrollees.

B. Amendments:

None.

[9] *Id.*

By the Committee on Health Regulation; and Senators Flores, Negron, and Gaetz

588-02046A-12 2012730c1

A bill to be entitled

An act relating to Medicaid managed care plans; amending s. 409.9122, F.S.; requiring the Agency for Health Care Administration to establish per-member, per-month payments; substituting the Medicare Advantage Coordinated Care Plan for the Medicare Advantage Special Needs Plan; amending s. 409.962, F.S.; revising the definition of "eligible plan" to include certain Medicare plans; amending s. 409.967, F.S.; limiting the penalty that a plan must pay if it leaves a region before the end of the contract term; amending s. 409.974, F.S.; correcting a cross-reference; providing that certain Medicare plans are not subject to procurement requirements or plan limits; amending s. 409.977, F.S.; requiring dually eligible Medicaid recipients to be enrolled in the Medicare plan in which they are already enrolled; amending s. 409.981, F.S.; revising the list of Medicare plans that are not subject to procurement requirements for long-term care plans; amending s. 409.984, F.S.; revising the list of Medicare plans in which dually eligible Medicaid recipients are enrolled in order to receive long-term care; providing an effective date.

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

Section 1. Subsection (15) of section 409.9122, Florida Statutes, is amended to read:

588-02046A-12 2012730c1

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(15) The agency shall ~~may~~ establish a per-member, per-month payment for enrollees who are enrolled in a Medicare Advantage Coordinated Care Plan and who ~~Medicare Advantage Special Needs members that~~ are also eligible for Medicaid as a mechanism for meeting the state's cost-sharing obligation. The agency may also develop a per-member, per-month payment only for Medicaid-covered services for which the state is responsible. The agency shall develop a mechanism to ensure that such per-member, per-month payment enhances the value to the state and enrolled members by limiting cost sharing, enhances the scope of Medicare supplemental benefits that are equal to or greater than Medicaid coverage for select services, and improves care coordination.

Section 2. Subsection (6) of section 409.962, Florida Statutes, is amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(6) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, ~~or~~ a provider service network authorized under s. 409.912(4)(d), or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391. For purposes of dually eligible Medicaid and Medicare recipients enrolled in the managed medical assistance program and the long-term care managed care program, the term also includes entities

qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, ~~and~~ Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Section 3. Paragraph (h) of subsection (2) of section 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:

(h) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per-enrollee ~~per enrollee~~ penalty of up to 3 months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained ~~requirement~~ pursuant to s. 641.225(1) which is attributable to the provision of coverage to Medicaid enrollees. Plans shall provide at least 180

days' notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions~~,~~ pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to provide for the transition of enrollees to other plans, and phase in ~~phase-in~~ the terminations over a time period sufficient to ensure a smooth transition.

Section 4. Subsection (2) of section 409.974, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

409.974 Eligible plans.—

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitted ~~submitting~~ a response.

The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as determined ~~defined~~ by the agency pursuant to s. 409.975(1) ~~409.975(2)~~. The agency shall exercise a preference for plans with a provider network in which more than ~~over~~ 10 percent of the providers use electronic health records, as defined in s. 408.051. When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

(5) MEDICARE PLANS.—Participation by an entity qualified under 42 C.F.R. PART 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and is not subject to the procurement requirements or regional plan limits of this section if the plan's Medicaid enrollees in the region consist exclusively of its current Medicare enrollees who are dually eligible for Medicaid and Medicare services. Otherwise, such organizations and plans are subject to all procurement requirements.

Section 5. Subsection (1) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s.

409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If ~~When~~ a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. If a recipient is dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity listed in s. 409.974(5), the agency shall automatically enroll the recipient in that plan for Medicaid services if the plan is currently under contract with the agency pursuant to s. 409.974(5). Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

Section 6. Subsection (5) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(5) MEDICARE PLANS.—Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and is not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of its current Medicare enrollees ~~recipients~~ who are deemed dually eligible for Medicaid and Medicare services.

Otherwise, such organizations and plans ~~Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans~~ are subject to all procurement requirements.

Section 7. Subsection (1) of section 409.984, Florida Statutes, is amended to read:

409.984 Enrollment in a long-term care managed care plan.—

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is under contract with the agency ~~currently participating in the long-term care managed care program~~. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

Section 8. This act shall take effect July 1, 2012.

agency for persons with disabilities
State of Florida

Medicaid Waiver Update

Rick Scott
Governor

Michael P. Hansen
Director

Monthly Surplus/Deficit Report

	FY 2011-2012 APD Waiver Expenditures	GR Budget Forecast	GR Actual Expenditures	GR Budget Less GR Expenditures
1	Appropriation	$ 357,690,175	$ -	$ -
2	July Expenditures	$ 9,091,015	$ 9,020,865	$ 70,150
3	August Expenditures	$ 29,575,695	$ 37,177,077	$ (7,601,382)
4	September Expenditures	$ 27,504,076	$ 27,697,467	$ (193,391)
5	October Expenditures	$ 29,804,624	$ 31,364,765	$ (1,560,141)
6	November Expenditures	$ 28,991,745	$ 38,374,871	$ (9,383,126)
7	December Expenditures	$ 32,209,227	$ 28,525,679	$ 3,683,548
8	January Expenditures	$ 27,928,155	$ -	$ -
9	February Expenditures	$ 28,189,313	$ -	$ -
10	March Expenditures	$ 29,005,217	$ -	$ -
11	April Expenditures	$ 29,592,357	$ -	$ -
12	May Expenditures	$ 28,407,418	$ -	$ -
13	June Expenditures	$ 33,419,396	$ -	$ -
14	Certified Forward – July	$ 21,036,621	$ -	$ -
15	Certified Forward – August	$ 1,999,204	$ -	$ -
16	Certified Forward – September	$ 936,111	$ -	$ -
17	Total FY 2011-2012 Actual Expenditures	$ 357,690,175	$ -	$ (14,984,342)
18	FY 2010-2011 Carry Forward Balance	$	$ 10,515,592	$ (10,515,592)
19	Two Year Accrued GR Deficit			$ (25,499,934)
		Estimated GR Available by Month	AHCA Invoice Amount	

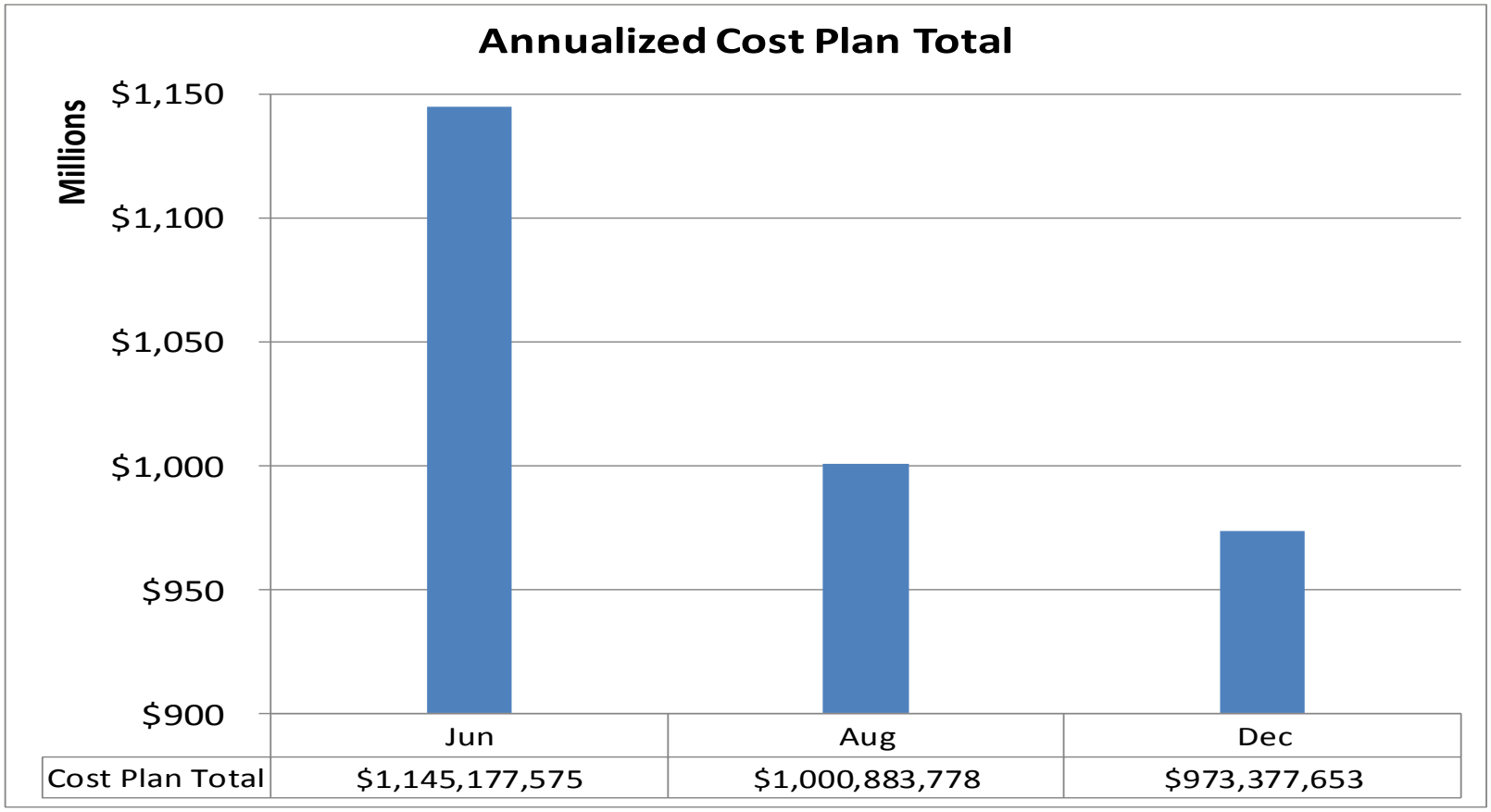
Questions?

Michael_Hansen@apd.state.fl.us
www.apdcares.org

Additional Information

Cost-Containment Initiatives

Cost-Containment Results

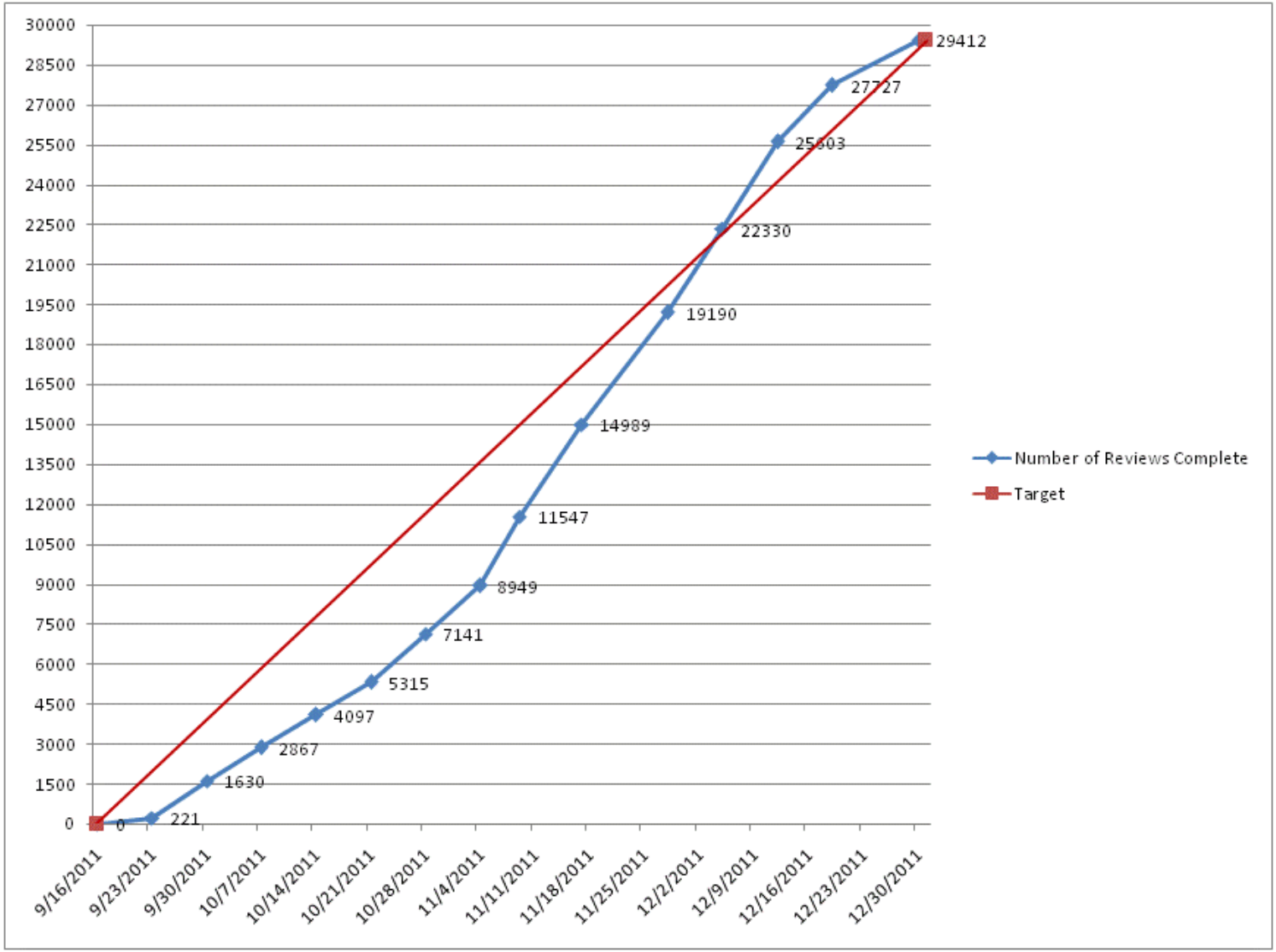


	Jun	Aug	Dec
Cost Plan Total	$1,145,177,575	$1,000,883,778	$973,377,653

Average annual cost plans fell from $37,595 to $32,987 per recipient
Total Cost Plans Reduction: $171.8 million

Results of Cost Plan Review Initiative – 12/31/11

- **29,412 Cost Plan Reviews Completed (100%)**
- **$20 M Fiscal Year Cost Plan Reductions Projected**
- **$34 M Annualized Cost Plan Reductions Projected**



Cost-Containment Initiatives *(continued)*

Cost-Containment Initiative		Progress	Implementation Date	Projected Annual Savings
1.	Standardize Residential Habilitation – Intensive Behavior rates	• Six daily rates established to cover varying needs of clients • All providers have signed new waiver services agreements • Stronger Provider Network	1/1/12	$2,021,417

Cost-Containment Initiatives *(continued)*

Cost-Containment Initiative		Progress	Implement Date	Projected Annual Savings
2.	Collect fees for Residential Habilitation settings	• Analysis completed • Plan developed for payment submission • Rule draft under development • Public meeting held November 4 for stakeholder input • Drafts and notice sent for OFARR review • Policy will account for federally approved exemptions only	1/1/12	$8,000,000 Preliminary Estimate

Cost-Containment Initiatives *(continued)*

Cost-Containment Initiative		Progress	Projected Target Date	Projected Annual Savings
3.	Reduce rates for therapy assessments and all nursing services to the Medicaid State Plan rate	• Nursing services and therapy assessments have comparable MSP rates that are lower than current waiver rates • Rates will be revised to match MSP rates	3/31/12	$1,268,174

Additional Information

iBudget Implementation

iBudget Implementation

Requirements of Law	Implementation Plan
Establishes iBudget system in Section 393.0662, F.S.	
• Requires use of an allocation algorithm and methodology based on characteristics such as age, living situation, formal assessment determined valid and reliable by the Agency and other assessment processes.	Uses the algorithm based on the statutory criteria, calibrated to the appropriation.
• The client's allocation may be increased due to an extraordinary need that would place the health and safety of the client, the client's caregiver or the public in serious jeopardy.	Provides allotment to meet extraordinary needs for services essential for health and safety.
• Permits adjustment due to one-time or temporary needs that would place health and safety in serious jeopardy or due to a significant increase in need for services after the beginning of the service year that would jeopardize health and safety.	Continued review by the Director of any increases due to changing needs.
• Proviso language in the General Appropriations Act (GAA) freezes individual cost plans and requires fiscal and operational controls to manage waiver spending within the legislative appropriation.	Freezes cost plans at current level unless iBudget amount with extraordinary need adjustment is lower.

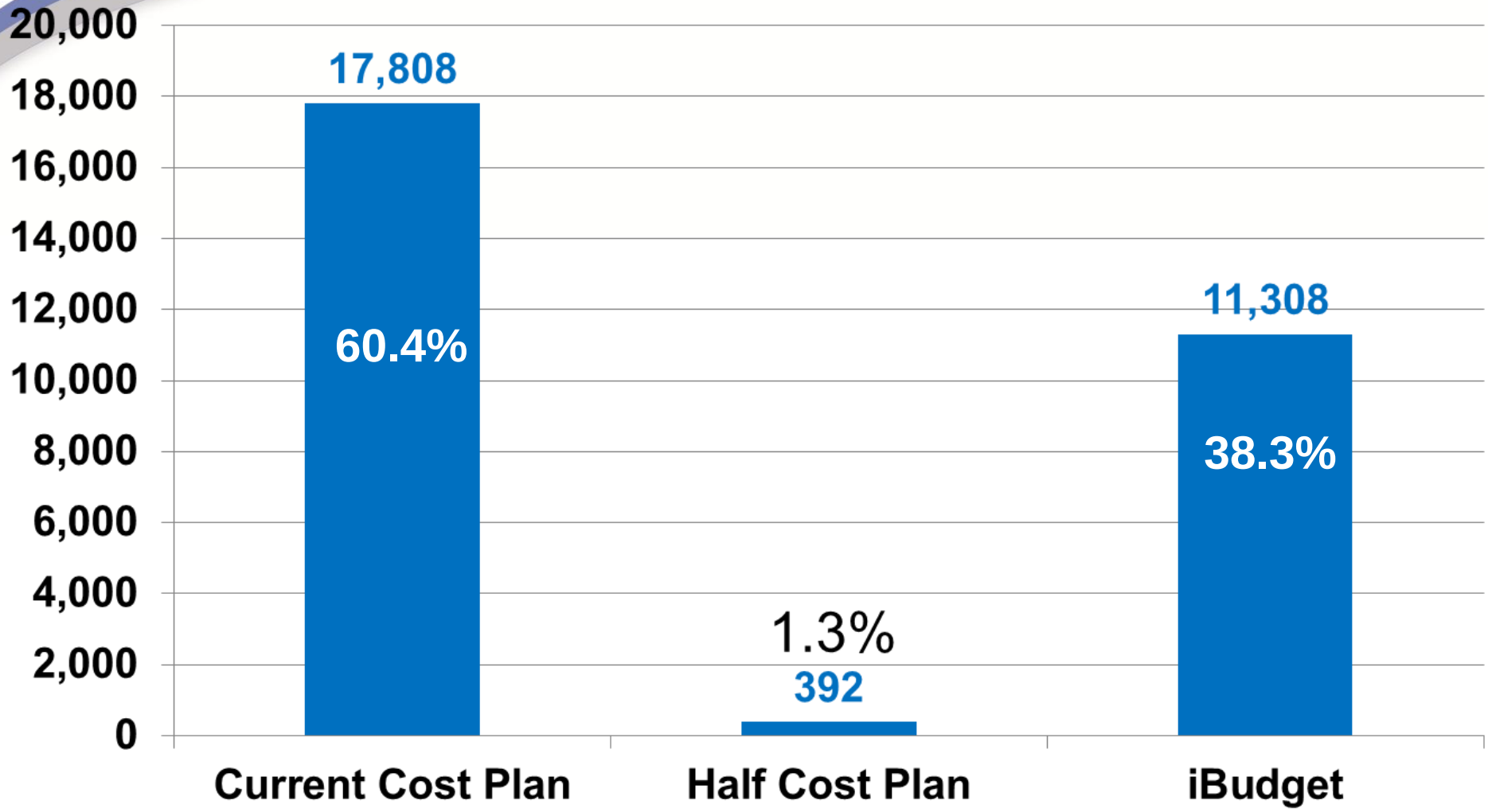
iBudget Implementation (continued)

- Funding methodology for iBudget:
  - Uses current cost plan to determine level of extraordinary needs. Increases iBudget algorithm for extraordinary needs to not jeopardize health and safety.
  - Does not increase any cost plan.
  - Does not decrease any cost plan more than 50%, per s. 393.0662 (3) (b) F.S.
- Additional savings from other cost-containment initiatives and individual cost plan reviews will continue.

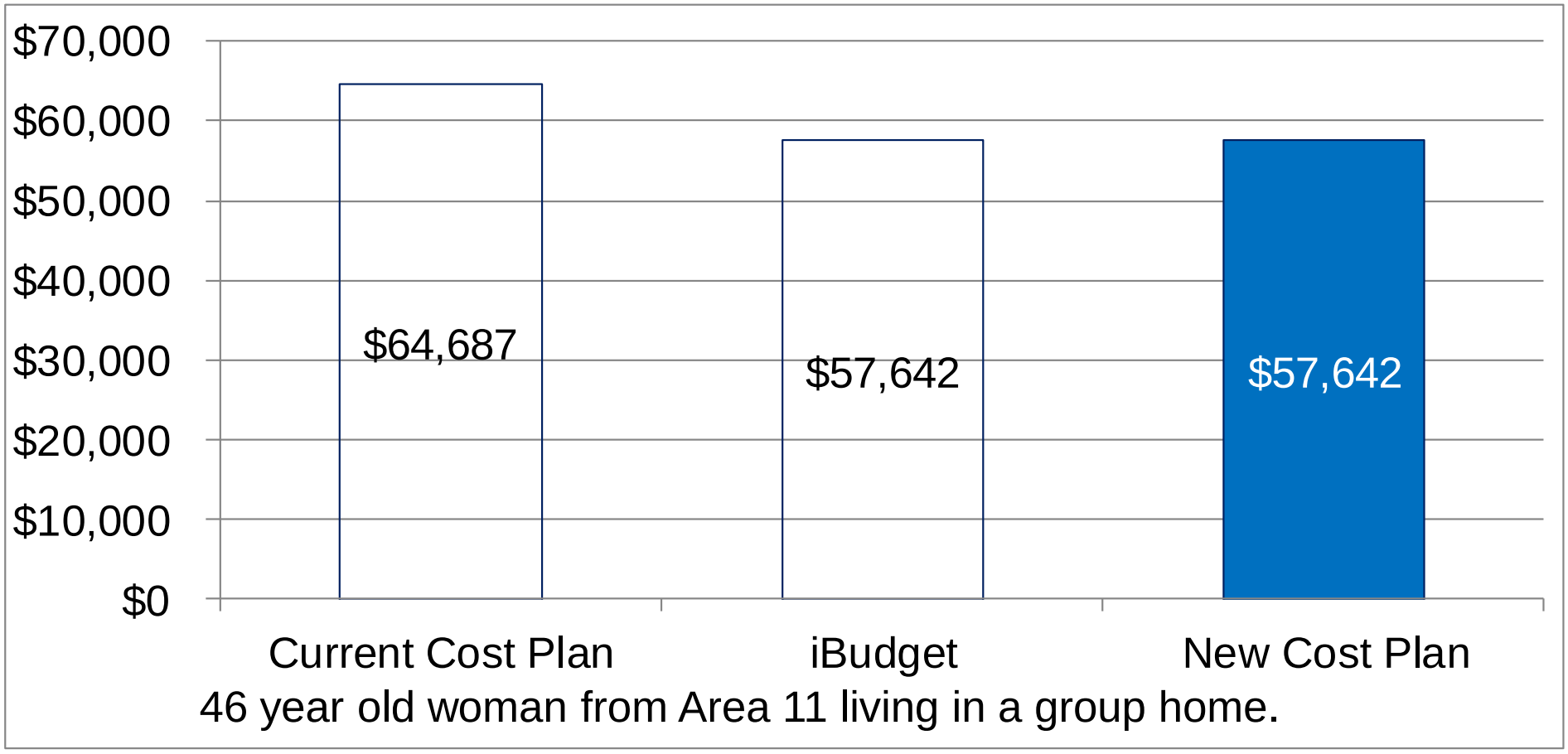
iBudget Implementation (continued)

- Calculation Provides:
  - Compliance with statutory requirements of aligning expenditures within appropriations.
  - Extraordinary needs of the population including Adult Day Training for those in family homes or living independently.
  - Flexibility and simplicity of iBudget design.
- Model costs $882.9 million.
- If expenditures equal 94.3% of cost plans, expenditures would equal Governor's Recommended Budget Appropriation.

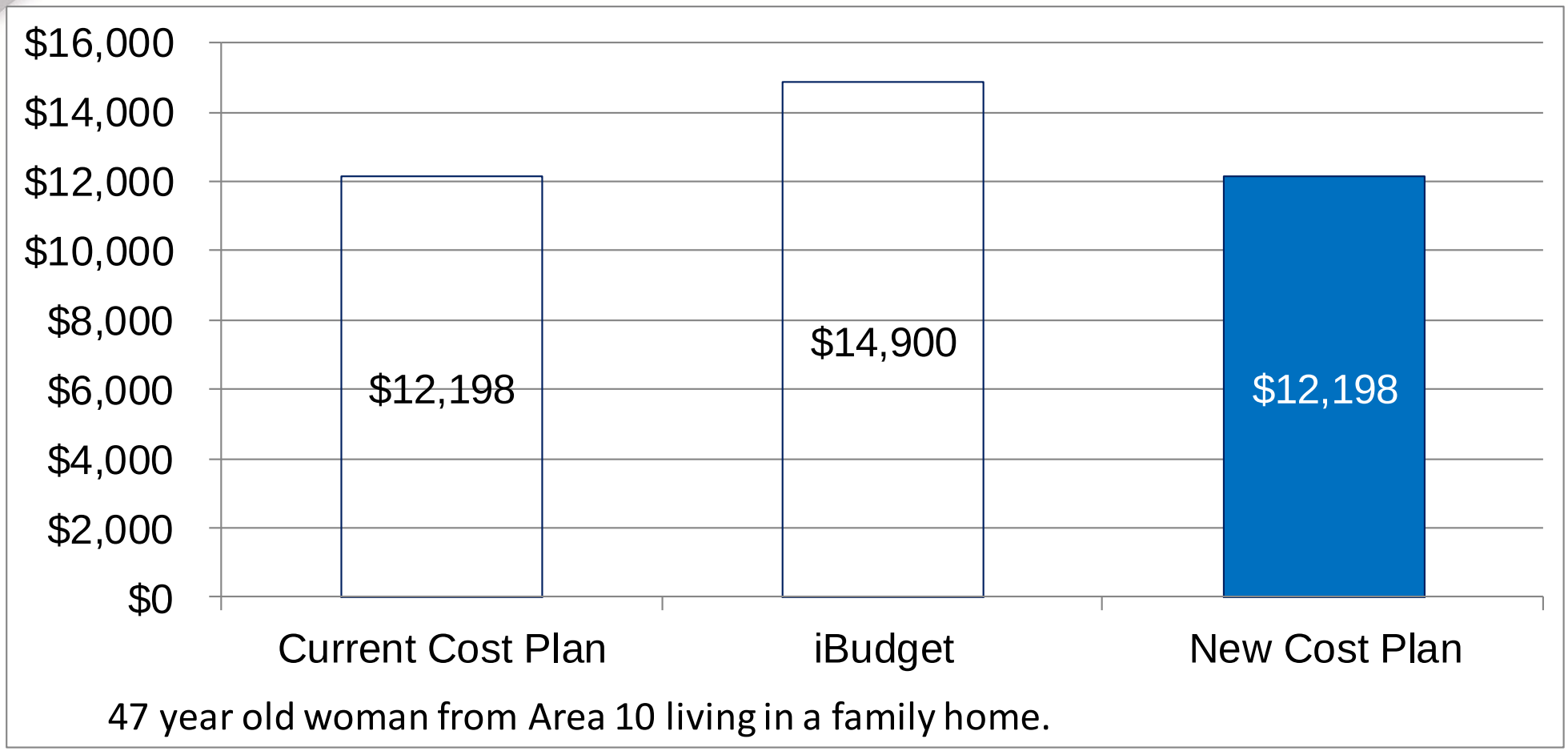
New Cost Plan Basis



Example 1

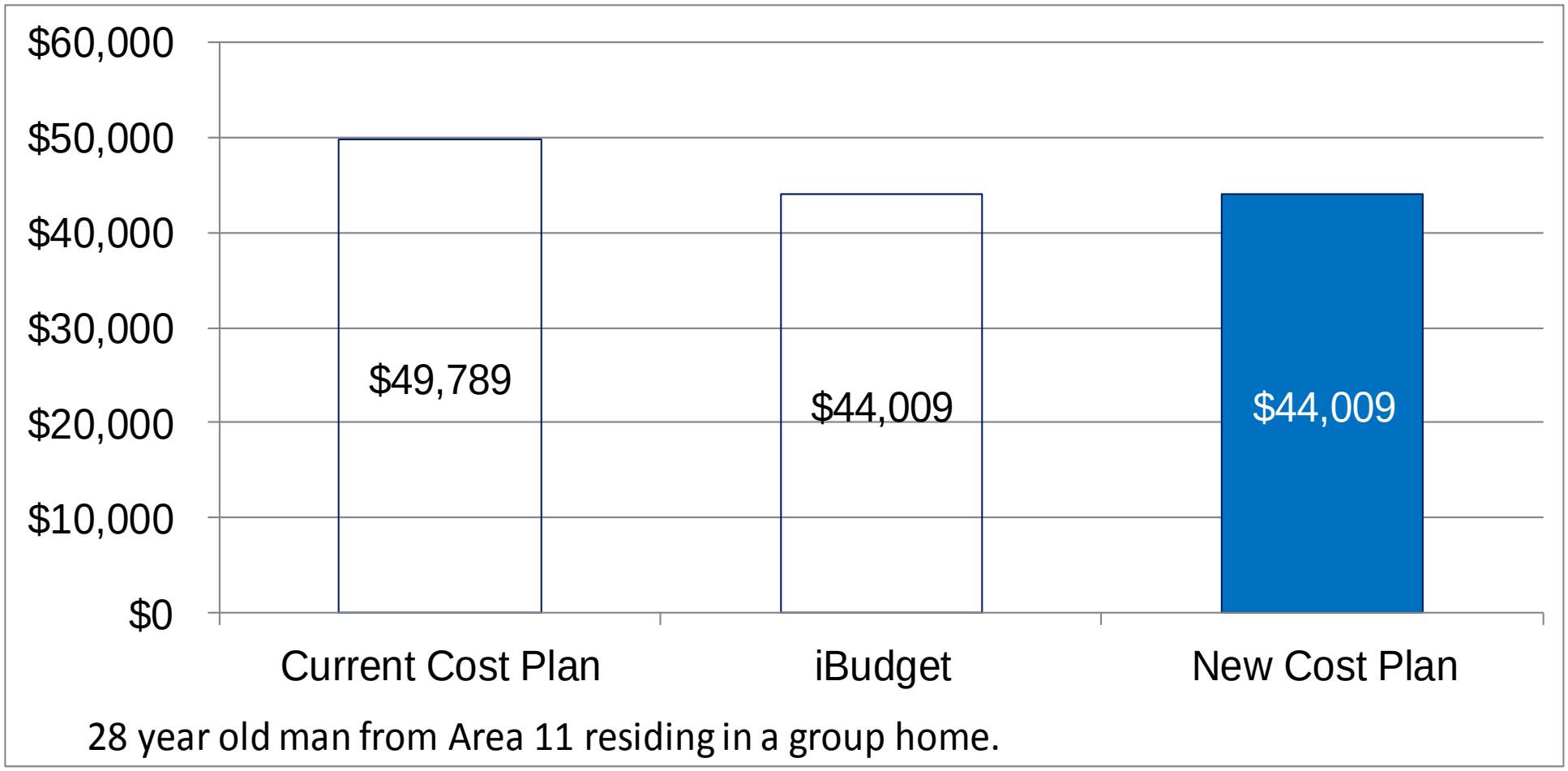

$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$64,687
$57,642
$57,642
Current Cost Plan
iBudget
New Cost Plan
46 year old woman from Area 11 living in a group home.

Example 2



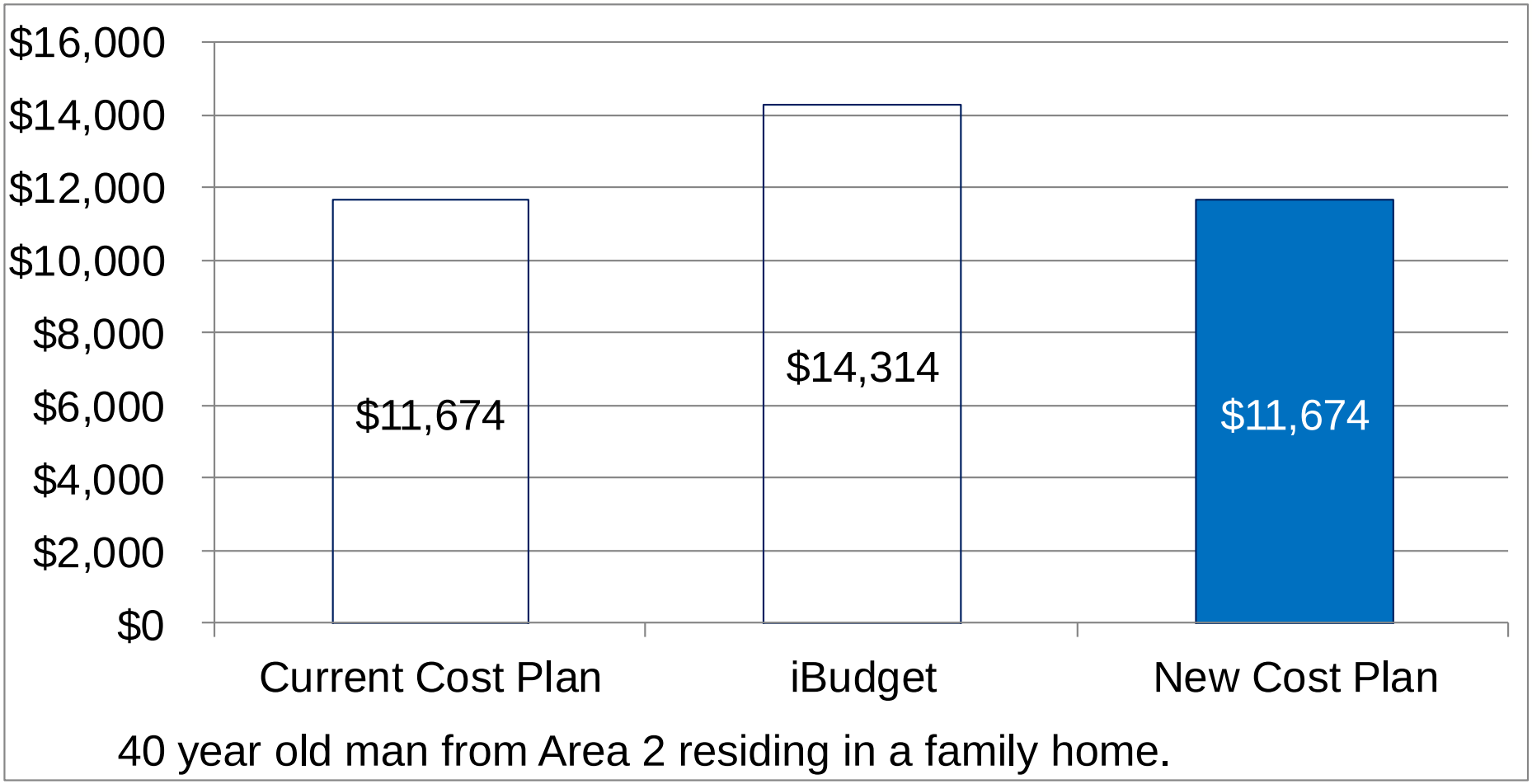
47 year old woman from Area 10 living in a family home.

Example 3



28 year old man from Area 11 residing in a group home.

Example 4


$16,000
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$11,674
$14,314
$11,674
Current Cost Plan
iBudget
New Cost Plan
40 year old man from Area 2 residing in a family home.

The Florida Senate

Committee Agenda Request

To: Senator Joe Negron, Chair
Committee on Health and Human Services Appropriations

Subject: Committee Agenda Request

Date: November 17, 2011

I respectfully request that **Senate Bill # 316**, relating to Alzheimer's Disease, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Stephen R. Wise
Florida Senate, District 5

File signed original with committee office

S-020 (03/2004)

The Florida Senate

Committee Agenda Request

To: Senator Joe Negron, Chair
Committee on Health and Human Services Appropriations

Subject: Committee Agenda Request

Date: December 13, 2011

I respectfully request that **Senate Bill #470**, relating to chiropractic medicine, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Dennis L. Jones, D.C.
Florida Senate, District 13

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)

1/24/12
Meeting Date

Topic Liposuction
Bill Number 544 *(if applicable)*

Name Chris Nland
Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 1000 Riverside Avenue #115 *Street*
Phone 904-355-1555

Jacksonville FL 32204 *City* *State* *Zip*
E-mail nJandlawe aol.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Society of Plastic Surgeons

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

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

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

S-001 (10/20/11)

W

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/24/12
Meeting Date

Topic Health Care
Bill Number SB 544 *(if applicable)*

Name Holly Miller
Amendment Barcode _____ *(if applicable)*

Job Title Assistant General Counsel

Address 1430 E Piedmont Drive *Street*
Phone 850 224 6496

Tallahassee FL 32308 *City* *State* *Zip*
E-mail hmiller@flmedical.org

Speaking: ☒ For ☐ Against ☐ Information

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 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

W

01/24/12
Meeting Date

Topic Medicaid Managed Care

Bill Number CS/SB 730 *(if applicable)*

Name Michael W. Garner

Amendment Barcode *(if applicable)*

Job Title President & CEO

Address 200 W. College Ave., Suite 104 *Street*

Phone (850) 386-2904

Tallahassee Florida 32301 *City State Zip*

E-mail michael@fahp.net

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Association 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 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

W

Meeting Date

Topic MEDICAID / MEDICARE

Bill Number 730 *(if applicable)*

Name JENNIFER GREEN

Amendment Barcode *(if applicable)*

Job Title CONSULTANT

Address P.O. BOX 390 *Street*

Phone

TLH FL 32302 *City State Zip*

E-mail

Speaking: ☑ For ☐ Against ☐ Information

Representing HUMANA, INC.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/24/12.
Meeting Date

Topic APD

Bill Number _____ *(if applicable)*

Name Michael P. Hansen

Amendment Barcode _____ *(if applicable)*

Job Title Director

Address 4030 Esplanade Way, Suite 380
Street
Tallahassee FL 32399
City *State* *Zip*

Phone 850-

E-mail michael_hansen@apd.state.fl.us

Speaking: ☐ For ☐ Against ☑ Information

Representing Agency for Persons w/ Disabilities-

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/24/12
Meeting Date

Topic Agency for Persons w/ Disabilities

Bill Number _____ *(if applicable)*

Name Craig A. Cook, Ph.D

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 2451 Regent St.
Street
Orlando FL 32804
City *State* *Zip*

Phone 407-692-2101

E-mail ccook@myaahmory

Speaking: ☑ For ☐ Against ☐ Information

Representing Families and Providers

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-24-12
Meeting Date

Topic APD Funding — Bill Number _____ *(if applicable)*

Name Sandra Spann — Amendment Barcode _____ *(if applicable)*

Job Title Co-Director

Address 1200 Circle Dr — Phone 850-830-2378
Street

DeFuniak Sps FL 32435 — E-mail sandra.spann@rhd.org
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing Resources for Human Development

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-24-12
Meeting Date

Topic APD Funding — Bill Number _____ *(if applicable)*

Name Frank Howard — Amendment Barcode _____ *(if applicable)*

Job Title client

Address 1200 Circle Dr — Phone 850-951-0037
Street

DeFuniak Sps FL 32435 — E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Representing Resources for Human Development

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-24-12
Meeting Date

Topic HEALTH CARE — Bill Number _____ *(if applicable)*

Name WILLIAM F JOHNSON SR — Amendment Barcode _____ *(if applicable)*

Job Title FATHER AND LEGAL GUARDIAN

Address 29415 DAVID C — Phone _____
Street

TAVARES FL 32778 — E-mail _____
City *State* *Zip*

Speaking: ☐ For ☒ Against (CUTS) ☐ Information

Representing SON, W.F. JOHNSON JR (GROUP HOMES MEDWAIVERS)

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

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

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

S-001 (10/20/11)

Speech problem

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/24/12
Meeting Date

Topic [illegible] For People w/ Disabilities — Bill Number _____ *(if applicable)*

Name Antonio Alston — Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 456 Lk. Badge Cv. — Phone 407-884-0471
Street

Apopka FL 32703 — E-mail gntony09@bellsouth.net @yahoo.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information

Representing _____

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

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

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

S-001 (10/20/11)

CourtSmart Tag Report

Room: EL 110 **Case:** **Type:**
Caption: Senate Budget Subcommittee on Health and Human Services Appropriations **Judge:**

Started: 1/24/2012 1:00:48 PM
Ends: 1/24/2012 2:05:43 PM Length: 01:04:56

1:00:50 PM	Meeting called to order
1:00:53 PM	Roll call
1:01:21 PM	Opening remarks - Chairman
1:01:26 PM	Tab 2 - CS/SB 316 (Senator Wise)
1:02:30 PM	Roll call - (5 Yeas, 0 Nays)
1:02:55 PM	Bill reported Favorable
1:03:15 PM	Tab 1 - CS/SB 544 (Senator Sobel)
1:09:11 PM	Public Testimonies:
1:09:22 PM	Chris Nuland, Florida Society o Plastic Surgeons
1:10:45 PM	Roll call (6 Yeas, 0 Nays)
1:11:29 PM	Bill reported Favorable
1:11:43 PM	Tab 3 - CS/SB 450 (Senator Oelrich)
1:14:29 PM	Roll call (6 Yeas, 0 Nays)
1:14:46 PM	Bill reported Favorable
1:14:50 PM	Tab 6 - CS/SB 730 (Senator Flores)
1:15:58 PM	Roll call (7 Yeas, 0 Nays)
1:16:43 PM	Bill reported Favorable
1:16:48 PM	Senator Gaetz and Oelrich made motion to vote yea after roll call on bills they missed (Fav)
1:17:40 PM	Chair to Senator Rich
1:18:28 PM	Tab 7 - Review and Discussion of FY 2012-2013 Budget Issues Relating to:...
1:18:37 PM	Mike Hanson, Director, Agency for Persons with Disabilities
1:28:22 PM	Tab 4 - CS/SB 470 (Senator Jones)
1:29:11 PM	Barcode 547226 (Garcia)
1:29:31 PM	Adopted (RCS)
1:30:57 PM	Roll call (5 Yeas, 1 Nay)
1:31:24 PM	Bill reported Fav/CS
1:31:40 PM	Back to Tab 7 - Mike Hansen (continued)
1:41:42 PM	Public Testimonies:
1:41:49 PM	Craig A. Cook, Ph.D.
1:45:07 PM	Sandra Spann, Resources for Human Development
1:47:50 PM	Frank Howard, Resources for Human Development
1:49:21 PM	William Johnson, Sr.
1:57:49 PM	Antonio Alston
2:04:09 PM	Closing remarks
2:05:09 PM	Senator Negron - Motion to vote yea after roll call on SB 470 (Fav)
2:05:35 PM	Adjourned