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| **Tab 1** | **CS/SB 122** by **CF, Rouson (CO-INTRODUCERS) Berman, Hooper, Book, Rader**; (Compare to CS/H 00043) Child Welfare |

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| 251124 | A | S | RCS | AHS, Rouson | Delete L.179 - 221: | 02/25 03:42 PM |
| 172158 | A | S | RCS | AHS, Harrell | Delete L.351: | 02/25 03:42 PM |
| 617230 | A | S | RCS | AHS, Harrell | Delete L.364 - 370. | 02/25 03:42 PM |
| 522422 | A | S | RCS | AHS, Rouson | Delete L.371 - 509: | 02/25 03:42 PM |
| 412980 | A | S | RCS | AHS, Rouson | Delete L.608 - 610: | 02/25 03:42 PM |
| 894626 | A | S | RCS | AHS, Rouson | Delete L.718 - 733. | 02/25 03:42 PM |
| 409736 | A | S | RCS | AHS, Rouson | btw L.733 - 734: | 02/25 03:42 PM |

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| **Tab 2** | **CS/SB 714** by **HP, Hutson**; (Compare to CS/H 00389) Testing for and Treatment of Influenza |

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| **Tab 3** | **SB 926** by **Harrell**; (Compare to H 00077) Health Care Practitioner Licensure |

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| **Tab 4** | **CS/SB 1094** by **HP, Diaz**; (Similar to CS/CS/H 00599) Consultant Pharmacists |

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| **Tab 5** | **CS/SB 1206** by **HP, Harrell**; (Compare to 1ST ENG/H 00575) Applied Behavior Analysis Services |

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| **Tab 6** | **CS/SB 1296** by **HP, Berman (CO-INTRODUCERS) Rodriguez**; (Compare to CS/CS/CS/H 00713) Health Access Dental Licenses |

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| **Tab 7** | **CS/SB 1338** by **BI, Wright (CO-INTRODUCERS) Harrell, Rodriguez, Perry**; (Compare to CS/H 07045) Prescription Drug Coverage |

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| 636790 | A | S | RCS | AHS, Wright | Delete L.210 - 508: | 02/25 04:03 PM |

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| **Tab 8** | **CS/SB 1544** by **HP, Albritton**; (Identical to CS/H 01373) Long-term Care |

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| **Tab 9** | **CS/SB 1726** by **HP, Bean**; (Similar to CS/CS/H 00731) Agency for Health Care Administration |

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| 441796 | D | S | RCS | AHS, Bean | Delete everything after | 02/25 04:16 PM |
| 860528 | AA | S | RCS | AHS, Bean | Delete L.113: | 02/25 04:16 PM |
| 127166 | AA | S | RCS | AHS, Bean | btw L.1393 - 1394: | 02/25 04:16 PM |
| ~~283312~~ | AA | S | WD | AHS, Rader | Delete L.2314 - 2417: | 02/25 04:16 PM |
| ~~588700~~ | AA | S | WD | AHS, Rader | Delete L.2315 - 2424: | 02/25 04:16 PM |

**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

**APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES**
**Senator Bean, Chair**
**Senator Harrell, Vice Chair**

**MEETING DATE:** Tuesday, February 25, 2020
**TIME:** 1:00—4:00 p.m.
**PLACE:** *Pat Thomas Committee Room,* 412 Knott Building

**MEMBERS:** Senator Bean, Chair; Senator Harrell, Vice Chair; Senators Book, Diaz, Farmer, Flores, Hooper, Passidomo, Rader, and Rouson

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 1 | **CS/SB 122**<br>Children, Families, and Elder Affairs / Rouson<br>(Compare CS/H 43, CS/H 7063) | Child Welfare; Citing this act as "Jordan's Law"; expanding the list of entities with access to certain records that relate to child abandonment, abuse, or neglect held by the Department of Children and Families; authorizing the parent or legal guardian of a child to request a second medical evaluation of a child under certain circumstances; requiring a lead agency to ensure that certain individuals receive specified training relating to head trauma and brain injuries in children younger than a specified age, etc.<br><br>CF 12/10/2019 Temporarily Postponed<br>CF 01/21/2020 Fav/CS<br>AHS 02/25/2020 Fav/CS<br>AP | Fav/CS<br>Yeas 10 Nays 0 |
| 2 | **CS/SB 714**<br>Health Policy / Hutson<br>(Compare H 389) | Testing for and Treatment of Influenza; Requiring specified licensed pharmacists to report certain information to the Department of Health; authorizing pharmacists to test for and treat influenza and providing requirements relating thereto; requiring a pharmacy in which a pharmacist tests for and treats influenza to display and distribute specified information; providing limitations on the medications a pharmacist may administer to treat influenza; prohibiting a pharmacist from testing or treating patients under certain circumstances, etc.<br><br>HP 02/18/2020 Fav/CS<br>AHS 02/25/2020 Favorable<br>AP | Favorable<br>Yeas 6 Nays 2 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 3 | **SB 926**<br>Harrell<br>(Compare H 77, CS/CS/CS/H 115, CS/CS/CS/H 713, CS/H 1143, H 1269, CS/S 66, CS/CS/S 230, CS/S 356, CS/CS/CS/S 474, Linked CS/S 928) | Health Care Practitioner Licensure; Establishing that a physician licensed under the Interstate Medical Licensure Compact is deemed to be licensed under chapter 458; establishing that an osteopathic physician licensed under the Interstate Medical Licensure Compact is deemed to be licensed under chapter 459; deleting a provision classifying the failure to repay a student loan issued or guaranteed by the state or federal government in accordance with the terms of the loan as a failure to perform a statutory or legal obligation; implementing the Interstate Medical Licensure Compact in this state, etc.<br><br>HP 01/28/2020 Favorable<br>AHS 02/25/2020 Favorable<br>AP | Favorable<br>Yeas 9 Nays 0 |
| 4 | **CS/SB 1094**<br>Health Policy / Diaz<br>(Similar CS/CS/H 599) | Consultant Pharmacists; Requiring a pharmacist to complete additional training to be licensed as a consultant pharmacist; authorizing a consultant pharmacist to perform specified services under certain conditions; requiring a consultant pharmacist and a collaborating practitioner to maintain collaborative practice agreements; prohibiting a consultant pharmacist from diagnosing any disease or condition, etc.<br><br>HP 02/11/2020 Fav/CS<br>AHS 02/25/2020 Favorable<br>AP | Favorable<br>Yeas 10 Nays 0 |
| 5 | **CS/SB 1206**<br>Health Policy / Harrell<br>(Compare H 575) | Applied Behavior Analysis Services; Authorizing the Agency for Persons with Disabilities to establish a certification process for registered behavior technicians; requiring the agency to recognize the certification of registered behavior technicians awarded by a nonprofit corporation that meets specified requirements; providing an exemption from licensure requirements for certain individuals who are employed or under contract with certain entities providing applied behavior analysis services; revising the definition of the term “private instructional personnel” to include certain registered behavior technicians, etc.<br><br>HP 02/04/2020 Fav/CS<br>AHS 02/25/2020 Favorable<br>AP | Favorable<br>Yeas 10 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 6 | **CS/SB 1296**<br>Health Policy / Berman<br>(Compare CS/CS/CS/H 713, CS/H 1461, CS/CS/S 230) | Health Access Dental Licenses; Reviving, reenacting, and amending provisions relating to the application for a health access dental license and the renewal of such license, etc.<br><br>HP 01/14/2020 Fav/CS<br>AHS 02/25/2020 Favorable<br>AP | Favorable<br>Yeas 10 Nays 0 |
| 7 | **CS/SB 1338**<br>Banking and Insurance / Wright<br>(Compare CS/H 7045) | Prescription Drug Coverage; Authorizing the Office of Insurance Regulation to examine pharmacy benefit managers; requiring health insurers and health maintenance organizations, or pharmacy benefit managers on behalf of health insurers and health maintenance organizations, to annually report specified information to the office; specifying requirements relating to brand-name and generic drugs in contracts between pharmacy benefit managers and pharmacies or pharmacy services administration organizations, etc.<br><br>BI 01/21/2020 Not Considered<br>BI 01/28/2020 Fav/CS<br>AHS 02/25/2020 Fav/CS<br>AP | Fav/CS<br>Yeas 10 Nays 0 |
| 8 | **CS/SB 1544**<br>Health Policy / Albritton<br>(Identical CS/H 1373) | Long-term Care; Requiring aging resource center personnel to annually rescreen certain individuals with high priority scores for purposes of the statewide wait list for enrollment for home and community-based services; authorizing such personnel to administer rescreening for certain individuals with low priority scores; authorizing community-care-for-the-elderly services providers to dispute certain referrals; providing that a referral decision by adult protective service prevails, etc.<br><br>HP 02/04/2020 Fav/CS<br>AHS 02/25/2020 Favorable<br>AP | Favorable<br>Yeas 10 Nays 0 |
| 9 | **CS/SB 1726**<br>Health Policy / Bean<br>(Similar CS/H 731) | Agency for Health Care Administration; Requiring birth centers to report certain deaths and stillbirths to the agency; revising provisions requiring the agency to conduct licensure inspections of nursing homes; removing the requirement that the agency annually report to the Governor and the Legislature by a specified date on the progress of implementation of electronic prescribing; revising the length of managed care plan contracts procured by the agency beginning during a specified timeframe, etc.<br><br>HP 01/28/2020 Fav/CS<br>AHS 02/25/2020 Fav/CS<br>AP | Fav/CS<br>Yeas 8 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
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| | 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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 122 (603180) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senators Rouson, Berman, Hooper, and Book |
| SUBJECT: | Child Welfare |
| DATE: | February 25, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Preston | Hendon | CF | **Fav/CS** |
| 2. | Sneed | Kidd | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/CS/SB 122 is titled "Jordan's Law" and makes a number of changes to the laws related to the child welfare system in an attempt to address issues that were identified in the case of Jordan Belliveau, a two-year old boy who was killed by his mother in Pinellas County.

The bill requires specified child welfare professionals and law enforcement officers to receive training developed by the Department of Health on the recognition of and response to head trauma and brain injury in children under six years old. The bill also requires Guardian ad Litem (GAL) program staff to receive training developed by the GAL training curriculum committee on the recognition of and responses to head trauma and brain injury in children under six years old.

The bill also:

- Requires the Department of Children and Families (DCF or department), in collaboration with the Florida Institute for Child Welfare (institute), to develop and implement a comprehensive uniform child welfare workforce framework based on a nationally recognized model and specifies issues to be addressed.
- Conforms education and training requirements to the new child welfare workforce framework.
- Allows credentialing entities that certify child welfare personnel to access certain records held by the department related to child abuse and neglect and provides additional duties for

the department and third party credentialing entities related to ethics and professional conduct violations.
- Authorizes a parent or legal guardian of a child removed from his or her home as a result of a medical evaluation performed by a Child Protection Team, to request a second, independent evaluation by a physician who has met the qualifications of s. 39.303(b), F.S., in order to determine whether the child has been the victim of abuse or neglect. Requires the court to consider the second evaluation when determining whether to remove a child from the home.
- Authorizes the DCF to pilot the effectiveness of case management services in CBCs serving up to three judicial circuits with high removal rates, significant budget deficits and high case management turnover, and have experienced significant increases in children entering out-of-home care.
- Revises the mission of the institute to include advancing the well-being of children and families who are involved with, or at risk of becoming involved with, the child welfare system by facilitating and supporting statewide partnerships to develop competency-based education, training, and support to prepare a diverse group of social work professionals for careers in child welfare.

The bill is expected to have an indeterminate fiscal impact on state expenditures. See Section V.

The bill takes effect July 1, 2020.

## II. Present Situation:

**Jordan Belliveau**

Jordan Belliveau, Jr., was killed by his mother in September 2018 when he was two years old. At the time of his death, the family was under court-ordered protective supervision as Jordan, who had been removed from his parent's custody in October 2016, was reunified with his mother, 21-year old Charisee Stinson, in May 2018. In addition to the open service case, there was also an active child abuse investigation due to ongoing domestic violence between his mother and father, 22-year-old Jordan Belliveau, Sr.

Due to lack of communication to the court, lack of communication between the Pinellas County Sheriff's Office and the department, and lack of evidence provided by Directions for Living, the contracted case management organization for Eckerd Connects, the community-based care lead agency (CBC), regarding the parent's case plan compliance, ongoing family issues that created an unsafe home environment for Jordan were never addressed. Jordan was initially reported missing by his mother in September 2018 and a statewide Amber Alert was issued. His body was found by law enforcement four days after his death. His mother was charged with aggravated child abuse and first-degree murder. His mother admitted to killing Jordan by hitting him, which caused the back of his head to hit a wall in their home.

**Special Review of the Case Involving Jordan Belliveau Jr.**

***Case Summary***

Given the circumstances of the case, former interim secretary of the department, Rebecca Kapusta, immediately initiated a special review to evaluate the circumstances surrounding

Jordan's death and to assess the services provided during the 17 months he remained removed from the home through his reunification with his mother in May 2018. The multidisciplinary team was not only comprised of individuals who specialize in child welfare, but also those with mental health, and domestic violence expertise (both from a treatment and law enforcement perspective) to address the reunification decision and actions that occurred when subsequent concerns were identified.[1]

Jordan's family first came in contact with the DCF in October 2016 when a report was made to the hotline alleging Jordan was in an unsafe home environment that included gang violence. Jordan was placed in foster care after his mother was unable to obtain alternative housing. He was subsequently adjudicated dependent on November 1, 2016, and placed in foster care. His parents were offered a case plan with tasks including finding stable housing and receiving mental health services and counseling.

Throughout Jordan's case, his mother and father were either non-compliant or only partially compliant with their case plans. Nevertheless, due to lack of communication to the court and lack of evidence provided by the case management organization, Directions for Living, regarding compliance, Jordan was eventually reunified with his mother and father. After reunification and while still under judicial supervision, domestic violence continued between the parents, with Jordan's father being arrested for domestic violence against Jordan's mother in July 2018. However, the incident was not immediately reported to the hotline upon his arrest, and thus the incident was not reported to the court at a hearing the next day regarding Jordan's reunification.

When the incident was reported to the hotline three weeks later, a child protective investigation was conducted by the Pinellas County Sheriff's Office. However, the investigator determined that Jordan was not currently in danger, and therefore, found there was no need to remove him from the home. Given the ongoing and escalating level of violence between the parents, the inability to control the situation in the home, and the risk of harm posed to Jordan should his parents engage in further altercations, an unsafe home environment should have been identified.

However, with no concerns for Jordan's safety raised after the investigation or during subsequent hearings, there was no consideration for an emergency modification of his placement and Jordan was reunited with his father. On August 31, 2018, a case manager visited Jordan's parents to discuss several issues regarding lack of cooperation with the Guardian ad Litem and case plan tasks. The case manager emphasized the continued need for Jordan's parents to participate in services or risk losing custody of Jordan. Less than 24 hours after the visit, Jordan was reported missing by his mother. Four days later, law enforcement found his body. Jordan's mother admitted to killing him by hitting him in a "moment of frustration" which "in turn caused the back of his head to strike an interior wall of her home."[2]

[1] Department of Children and Families, *Special Review of the Case Involving Jordan Belliveau, Jr*. (Jan. 11, 2019), available at http://www.dcf.state.fl.us/newsroom/docs/Belliveau%20Special%20Review%202018-632408.pdf . (Last visited November 15, 2019).
[2] *Id*.

***Findings in the Report***

- The decision to reunify Jordan was driven primarily by the parents' perceived compliance with case plan tasks and not behavioral change. There was a noted inability by all parties involved to recognize and address additional concerns that became evident throughout the life of the case. Instead, case decisions were solely focused on mitigating the environmental reasons Jordan came into care and failed to address the overall family conditions.
- Following reunification, policies and procedures to ensure child safety and wellbeing were not followed. In addition, Directions for Living case management staff did not take action on the mother's lack of compliance and her failure to participate with the reunification program prior to and following reunification.
- When the new child abuse report was received in August 2018, alleging increased volatility between the parents, the present danger was not appropriately assessed and identified. The assessment by the Pinellas County Sheriff's child protective investigator (CPI) was based solely on the fact that the incident wasn't reported to the hotline when it initially occurred. The CPI failed to identify the active danger threats occurring within the household that were significant, immediate, and clearly observable. Given the circumstances, a modification of Jordan's placement should have been considered.
- Despite the benefit of co-location, there was a noted lack of communication and collaboration between the Pinellas County Sheriff's Office CPI unit and Directions for Living case management staff in shared cases involving Jordan and his family, especially regarding the August 2018 child abuse investigation.
- In addition to the lack of communication and collaboration between frontline investigations and case management staff noted above, there was an absence of shared ownership between all entities involved throughout the life of Jordan's case, which demonstrates a divided system of care. In addition, the lack of multidisciplinary team approach resulted in an inability to adequately address the identified concerns independent of one another.
- The biopsychosocial assessments failed to consider the history and information provided by the parents and resulted in treatment plans that were ineffective to address behavioral change. Moreover, there was an over-reliance on the findings of the biopsychosocial assessments as to whether focused evaluations were warranted (e.g., substance abuse, mental health, domestic violence, etc.), despite the abundance of information to support such evaluations were necessary.[3]

***Conclusion***

The report's findings and conclusion do not indicate that Jordan's death was the result of any shortcomings or loopholes in the law or lack of training related to the identification of brain injury, but rather due to the multiple failures of individuals working with children in the child welfare system to communicate, coordinate and cooperate:

> Complex child welfare cases are difficult enough when high caseloads and continual staff turnover plague an agency. However, it is further impacted when those involved in the case (protective investigations, case management, clinical providers, legal, Guardians ad Litem, and the

[3] *Id.*

> judiciary) fail to work together to ensure the best decisions are being made on behalf of the child and their family.
>
> This case highlights the fractured system of care in Circuit 6, Pinellas County, with each of the various parts of the system operating independently of one another, without regard or respect as to the role their part plays in the overall child welfare system. Until the pieces of the local child welfare system are made whole, decision-making will continue to be fragmented and based on isolated views of a multi-faceted situation.[4]

**Training on Head Trauma and Brain Injury in Abused and Neglected Children**

***Head Trauma and Brain Injury in Children***

Abusive head trauma is a leading cause of child abuse deaths in children under five in the United States.[5] Head trauma and injuries can be mild, like a bump or bruise, or they can be more severe, like a concussion or a fractured skull bone, and may include internal bleeding and damage to the brain. A number of actions can cause head trauma and brain injury in children. The most commonly known physical abuse that results in a brain injury is shaken-baby syndrome[6]; however, head trauma and other forms of physical abuse, like hitting or striking a child, can cause brain injuries. Caregiver neglect can also cause brain injuries through inadequate supervision or by providing an unsafe home environment.

Additionally, other forms of abuse that do not involve physical abuse to the head, such as choking or strangling, can damage the brain. Disruption in oxygen to the brain, called hypoxia, can cause long-term disabilities and damage to a child's brain.[7]

***Current Brain Injury Training Requirements***

Currently, all case managers, Guardian ad Litem staff and volunteers, dependency court judges, child protective investigators and supervisors, Children's Legal Services' attorneys, and law enforcement officers are required to complete required training for their position. Typically, this is done as preservice and continuing education training. None of the required training includes the recognition of and response to head trauma and brain injury in a child under age six.[8]

**Education and Training Requirements for Child Welfare Staff**

***Training and Certification***

In 1986, the Legislature required the Department of Health and Rehabilitative Services (HRS) to establish, maintain and oversee the operation of child welfare training academies in the state for the expressed purpose of enabling the state to provide a systematic approach to staff development and training for dependency program staff. The Legislature further intended that

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[4] *Id*.
[5] Spies, EL, Ph.D. and Klevens, J., MD, Ph.D., *Fatal Abusive Head Trauma among Children Aged <5 Years – United States, 1999-2014* (May 27, 2016).
[6] Tina Joyce, Martin Huecker, *Pediatric Abusive Head Trauma (Shaken Baby Syndrome)*, available at: https://www.ncbi.nlm.nih.gov/books/NBK499836/ (last visited February 24, 2020).
[7] James E. Lewis, Ph.D., *Neuropsychological Evaluations of Children and Adults in Child Welfare Cases*, available at: http://centervideo.forest.usf.edu/clsneuropsych/start.html (last visited February 24, 2020).
[8] For specific training requirements, see ss. 25.385, 39.8296, 402.402, 409.988, 943.13 and 943.135, F.S.

this approach to training would aid in the reduction of poor staff morale and of staff turnover, positively impact the quality of decisions made regarding children and families and afford a better quality of care for children placed in out-of-home care.[9] The HRS established a number of training academies statewide that were widely recognized as a national model for child welfare workforce training.

In 2000, the Legislature authorized the department to create certification programs for its employees and service providers to ensure that only qualified employees and service providers provide client services. The department was authorized to develop rules that included qualifications for certification, including training and testing requirements, continuing education requirements for ongoing certification, and decertification procedures to be used to determine when an individual no longer meets the qualifications for certification and to implement the decertification of an employee or agent.[10] The department subsequently developed 11 types of certification designations for child protection professionals.

In 2011, at the urging of the CBCs, the Legislature eliminated the department's child welfare training program and removed the department's ability to create certification programs.[11]

***Education***

The college degrees most tailored to and associated with child welfare are the bachelor's and master's degrees in social work. During the first half of the 20th century, the federal government, in cooperation with universities and local agencies, established a child welfare system staffed by individuals with professional social work educations. Child welfare came to be viewed as a prestigious specialty within the social work profession.

In the 1990's, an increased recognition of child abuse led to enactment of state child abuse and neglect reporting laws and toll-free numbers to report abuse. This resulted in a large increase of child abuse reports, and resources for the preparation and support of additional staff needed to respond to the reports became inadequate. States moved quickly to hire additional employees to investigate abuse. One way to expand the workforce was to reduce staff qualifications. In response to having a varied workforce without similar expertise and training, agencies began to structure child welfare work to reduce its complexity and make it possible for people with fewer qualifications to adequately perform required tasks.

Several studies have found evidence that social work education, at either the bachelors of social work (BSW) or masters of social work (MSW) level, positively correlates with performance. A study conducted in Maryland public child welfare agencies found an MSW to be the best predictor of overall performance as measured by supervisory ratings and employee reports of work related competencies. A national study that measured competencies related to 32 job-

[9] Chapter 86-220, L.O.F. The first training academy was required to be operational by June 30, 1987 and be located at Tallahassee Community College.
[10] HB 2125, Chapter 2000-139. L.O.F.
[11] HB 279, Chapter 2011-163, L.O.F.

related duties found that both MSW and BSW staff were better prepared for child welfare work than their colleagues without social work education.[12]

Research conducted with staff in Kentucky's public child welfare agency also revealed that staff with social work degrees scored significantly better on state merit examinations, received somewhat higher ratings from their supervisors, and had higher levels of work commitment than other staff. A Nevada study showed that caseworkers who had a social work degree were significantly more likely to create a permanent plan for children in their caseloads within three years than their colleagues without social work education.[13]

In 2014, the Legislature required the department to set a goal of having at least half of all child protective investigators and supervisor's with a bachelor's degree or a master's degree in social work from a college or university social work program accredited by the Council on Social Work Education. Despite numerous studies and reports supporting the value of a formal social work education in child welfare, Florida has made little if any progress towards re-professionalizing the workforce. In fact, the state has seen a decline since 2016.

| Percentage of Child Protective Investigative Positions With Social Work Degree | | | |
|---|---|---|---|
| | **BSW** | **MSW** | **Either** |
| **2014** | | | 9.5% |
| **2016** | 12% | 3% | |
| **2019** | 11% | 2% | |

**The Florida Institute for Child Welfare**

In 2014, the Legislature established the Florida Institute for Child Welfare (FICW) at the Florida State University College of Social Work. The purpose of the FICW is to advance the well-being of children and families by improving the performance of child protection and child welfare services through research, policy analysis, evaluation, and leadership development.[14] The institute is required to:

- Maintain a program of research which contributes to scientific knowledge and informs both policy and practice.
- Advise the department and other organizations participating in the child protection and child welfare system regarding scientific evidence.
- Provide advice regarding management practices and administrative processes used by DCF and other organizations participating in the child protection and child welfare system and recommend improvements.
- Assess the performance of child protection and child welfare services based on specific outcome measures.

[12] The Florida Senate, Bill Analysis and Fiscal Impact Statement, SB 1666, March 12, 2014, available at: http://www.flsenate.gov/Session/Bill/2014/1666/Analyses/2014s1666.cf.PDF (Last visited November 30, 2019).
[13] *Id*.
[14] Section 1004.615, F.S.

- Evaluate the scope and effectiveness of preservice and inservice training for child protection and child welfare employees and advise and assist the department in efforts to improve such training.
- Assess the readiness of social work graduates to assume job responsibilities in the child protection and child welfare system and identify gaps in education, which can be addressed through the modification of curricula or the establishment of industry certifications.
- Develop and maintain a program of professional support including training courses and consulting services that assist both individuals and organizations in implementing adaptive and resilient responses to workplace stress.
- Participate in the department's critical incident response team, assist in the preparation of reports about such incidents, and support the committee review of reports and development of recommendations.
- Identify effective policies and promising practices, including, but not limited to, innovations in coordination between entities participating in the child protection and child welfare system, data analytics, working with the local community, and management of human service organizations, and communicate these findings to the department and other organizations participating in the child protection and child welfare system.
- Develop a definition of a child or family at high risk of abuse or neglect. Such a definition must consider characteristics associated with a greater probability of abuse and neglect.[15]

## III. Effect of Proposed Changes:

**Section 1** provides a short title. The bill is titled "Jordan's Law" after Jordan Belliveau, a two-year old child in Florida's child welfare dependency system, who was killed by his mother in September 2018.

**Section 2** amends s. 39.202, F.S., related to confidentiality of reports and records in cases of child abuse and neglect, to allow credentialing entities that certify child welfare personnel to access certain specified records held by the department related to child abuse and neglect. This will allow the credentialing entity to suspend or revoke the certification of child welfare personnel who work on cases involving children who are abused, neglected or abandoned.

**Section 3** amends s. 39.303, F.S., relating to Child Protection Teams, to require the teams to add information on the recognition of and response to head trauma and brain injury in children under six years old to currently mandated trainings developed for program and other employees of the department, employees of the Department of Health, and other medical professionals.

**Section 4** amends s. 39.401, F.S., relating to taking a child alleged to be dependent into custody, to authorize a parent or legal guardian of a child who is removed as a result of a determination by a medical evaluation performed by a Child Protection Team to request a second, independent evaluation be performed by a physician who has met the relevant qualifications of s. 39.303(b), F.S., in order to determine whether the child has been the victim of abuse or neglect. The bill requires the court to consider the evaluation when determining whether to remove a child from the home.

[15] *Id*.

**Section 5** amends s. 39.820, F.S., relating to definitions, to revise the terms "guardian ad litem" and "guardian advocate."

**Section 6** amends s. 39.8296, F.S., relating to the statewide Office of Guardian ad Litem, to require that training for a guardian ad litem include information on the recognition of and responses to head trauma and brain injury in children under six years old. The bill requires the training curriculum committee, rather than the statewide Guardian Ad Litem office, to develop guardian ad litem training programs, including the development of training on the recognition of and responses to head trauma and brain injury in children under six years old.

**Section 7** amends s. 402.40, F,S, relating to child welfare training and certification, to:

**Child Welfare Workforce Development Framework and Education Requirements**

- Require the department, in collaboration with the institute, to develop and implement a comprehensive uniform child welfare workforce framework based on a nationally recognized model and specifies the following components that must be addressed: recruitment and hiring; education and professional preparation; professional training and development; supervision; retention; caseload and workload; workforce well-being and support; work-life balance and flexible scheduling; agency culture and climate.
- Require the department to develop a protocol for screening candidates for child protective positions and give preference to certain candidates that have specific experience or educational training
- Require by January 1, 2021, the CBCs to submit to the department a plan and timeline for recruiting and hiring child welfare staff, which meet the same educational requirements for child protective staff. The plan and timeline must include the same recruiting and hiring requirements for child welfare staff employed by subcontractors.

**Workforce Training**

- Require the department to establish a comprehensive system to provide preservice and inservice competency-based training program curricula that all child welfare, including staff employed by a CBC and its subcontractor, are required to participate in and successfully complete.
- Require that the training program include information on the recognition of and responses to head trauma and brain injury in children under six years old.
- Allow the CBCs to develop supplemental training, if needed, but such training cannot not take the place of or conflict with required standardized statewide training.

**Workforce Certification**

- Require the department approved third-party credentialing entities to require that persons holding a child welfare certification to comply with the new training requirements as a condition of renewal or initial certification. Require the third-party credentialing entity to track and report compliance with this section.
- Require that all certified child welfare professionals follow the third-party credentialing entities code of ethical and professional conduct and disciplinary procedures:

- Require that the department, CBCs, sheriff's offices, and their contracted providers to report all allegations of suspected or known violations of ethical or professional misconduct standards to the department approved third-party credentialing entity.
- Require the third-party credentialing entity to review all case records involving the death of a child or other critical incident to ensure compliance with the entities code of ethical and professional conduct and disciplinary procedures.
- Require the department to provide the third-part credentialing entity with all reports necessary to conduct an investigation on all certified child welfare providers involved with the case.
- Require the department or a subcontracted employer of the certified staff to remove the individual from their duties that require certification as a condition of employment until an initial review is complete and the third-party credentialing entity determines whether an ethics case is warranted.
- Authorize the department to review the decisions of the third-party credentialing entity to deny, revoke, or suspend a certification of an individual.
- Allows a person that receives an adverse determination from a third-party credentialing entity to request an administrative hearing pursuant to ss. 120.569 and 120.57(1), F.S.
- Requires the third-party credentialing entity to track and monitor compliance with the entities code of ethical and professional conduct and disciplinary procedures.

**Section 8** amends s. 409.988, F.S., relating to duties of the CBCs, to require that training for all individuals providing care for dependent children include information on the recognition of and responses to head trauma and brain injury in children under six years old that is developed by the Child Protection Team program. The bill also requires lead agencies to ensure the participation and completion of training relevant to the individual's area of responsibly, rather than the receipt of general training.

The bill expands the type of services that the CBCs must provide to dependent children to include intensive family reunification services that combine child welfare and mental health services for families with dependent children under six years old.

**Section 9** creates s. 943.17298, F.S., relating to law enforcement training, to require that training for law enforcement officers include information on the recognition of and responses to head trauma and brain injury in children under six years old that is developed by the Child Protection Team program. Such training may either be a part of basic recruit training or continuing education or training.

**Section 10** amends s. 1004.615, F.S., relating to the Florida Institute for Child Welfare (institute), to revise the mission of the institute to include advancing the well-being of children and families who are involved with, or at risk of becoming involved with, the child welfare system by facilitating and supporting statewide partnerships to develop competency-based education, training, and support to prepare a diverse group of social work professionals for careers in child welfare. The bill removes a requirement that the department contract with the institute and instead requires the department to collaborate with the institute for the following:

- Design and dissemination of continuum of social work education and training;
- Identification of methods to promote continuing professional development and systems of workplace support for existing child welfare staff;

- Development of a best practice model for providing feedback on curriculum to social work programs;
- Creation of a Title IV-E program designed to provide professional education and monetary support to undergraduate and graduate social work students who intend to pursue or continue a career in child welfare.
- Evaluation and dissemination of evidence-based and promising practices in child welfare and the development of high-quality evaluation into new program models and pilots; and
- Provide consultation on the creation of the Office of Well-Being and Support within the department.

**Section 11** repeals s. 402.402, F.S., relating to child protection and child welfare personnel and attorneys employed by the department, to consolidate and eliminate requirements related to education and training which would be encompassed into or become unnecessary as a result of development of a new framework.

**Section 12** amends s. 409.996, F.S., relating to duties of the department, to allow the DCF, in collaboration with select CBCs, to establish a program to improve case management services for dependent children under six years old by:

- Limiting caseloads for case managers comprised solely of children under six years old to no more than 15 children per case manager.
- Including case managers in the program who are trained specifically in:
  - Critical child development for children under six years old.
  - Specific practices of child care for children under six years old.
  - The scope of community resources available to children under six years of age.
  - Working with a parent or caregiver and assisting him or her in developing the skills necessary to care for a child under six years old.
- Allowing dependent siblings served by the program to be assigned to the same case manager.
- Requiring the DCF to evaluate the permanency, safety, and well-being of children served through the program and submit a report to the Governor and Legislature by October 1, 2025.

The bill requires the DCF to choose CBCs in circuits with high removal rates, significant budget deficits, significant case management turnover, and the highest numbers of children in out-of-home care or a significant increase in the number of children in out-of-home care over the last three fiscal years. If the DCF chooses to establish such a program, the bill requires the department to select up to three CBCs to develop and implement the program.

**Section 13** amends s. 1009.25, F.S. relating to postsecondary fee exemptions, to delete a cross reference.

**Section 14** provides an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The CBCs will be required to ensure that individuals providing care for dependent children receive training on recognition of and response to head trauma and brain injury in children under six years old. However, the CBCs may be able to use or adapt training developed by the Department of Health (DOH) into the CBC's existing training curriculum at minimal or no cost.

C. Government Sector Impact:

The DOH may incur expenses related to developing additional training on brain injuries in children for the Child Protection Teams that investigate child abuse cases. The expenses are likely insignificant and can be absorbed within existing department resources.

PCS/CS/SB 122 also requires specified child welfare professionals, guardians ad litem, and law enforcement officers to receive training on the recognition of and response to head trauma and brain injury in children under six years old. The Department of Children and Families (DCF), Guardian ad Litem program, and the Department of Law Enforcement will likely be able to incorporate the necessary changes to their training curricula within existing resources.

Additionally, the bill is expected to have an indeterminate fiscal impact on the DCF to establish a program to provide a comprehensive system to provide both preservice and in-service child welfare competency-based training curricula for all child welfare staff, including all staff providing care for dependent children employed by a CBC or a subcontractor. Currently, the CBCs are required to provide training statewide. According

to the DCF, the fiscal impact to the department could be offset if the funding currently provided to the sheriff's offices and the CBCs for this purpose is transferred to the department.[16]

## VI. Technical Deficiencies:

Subsection (4) is unclear as to whether the department is to develop and implement a training program or only develop a course of instruction.

## VII. Related Issues:

The funding of preservice and inservice training currently is allocated to the DCF, sheriffs' offices, and CBCs. The department will have to identify the funds and move the funding from the sheriffs' offices and CBCs to the department. In addition, it may be challenging for the department to develop a training curriculum without additional funds.

## VIII. Statutes Affected:

The bill substantially amends the following sections of the Florida Statutes: 39.202, 39.303, 39.401, 39.820, 39.8296, 402.40, 409.988, 409.996, 1004.615, and 1009.25.

This bill creates 943.17298 of the Florida Statutes.

This bill repeals 402.402 of the Florida Statutes.

## IX. Additional Information:

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

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 25, 2020:**
The committee substitute:

- Removes the requirement that the DCF create an Office of Well-Being and Support and a helpline for child welfare workers to address work related stress.
- Corrects a drafting error that removed a reference to the third party credentialing entity.
- Clarifies the terms "guardian ad litem" and "guardian advocate."
- Adds the requirement for the DCF to establish a comprehensive preservice and inservice training program curricula that all child welfare staff, including staff employed by a CBC and its subcontractor, are required to participate in and successfully complete.

[16] The Department of Children and Families Agency Analysis, CS for SB 122, January 28, 2020. On file with the Senate Appropriations Subcommittee on Health and Human Services. The department states that "Title IV-E funding for preservice and inservice training is currently divided between the CBCs and the Department. The CBCs are currently appropriated $7,377,261 in training funding for preservice and inservice training. In addition, the funding currently used for the training of CPIs and sheriffs' staff responsible for conducting child protective investigations total $13,323,377. According to the department, the revenues will need to be retained by the department to cover the cost of preservice and inservice training."

- Allows the DCF to establish a pilot program for CBCs in three circuits with high removal rates, significant budget deficits and case management turnover, and high numbers of children in out-of-home care to improve case management services for dependent children under six years old by:
  - Limiting caseloads for certain case managers to no more than 15 children per case manager.
  - Including case managers who are trained in:
    - Critical child development for children under six years old.
    - Specific practices of child care for children under six years old.
    - The scope of community resources available to children under six years of age.
    - Working with a parent or caregiver and assisting him or her in developing the skills necessary to care for a child under six years old.
  - Requiring the DCF to submit a report that evaluates the permanency, safety, and well-being of children served through the program.

**Children, Families, and Elder Affairs on January 21, 2020:**

The bill does the following:

- Allows the CBCs to develop supplemental training if needed but it cannot not take the place of or conflict with required standardized statewide training.
- Allows credentialing entities to access certain specified records held by the department related to child abuse and neglect and provides additional responsibilities for the department and the credentialing entities related to ethics violations.
- Authorizes a parent or legal guardian of a child who is removed as a result of a determination by a medical evaluation performed by a Child Protection Team to request a second, independent evaluation be performed by a physician who has met the relevant qualifications of s. 39.303(b), F.S., in order to determine whether the child has been the victim of abuse or neglect. Requires the court to consider the evaluation when determining whether to remove a child from the home.

B. Amendments:

None.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** January 28, 2020

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I respectfully request that **Senate Bill # 122**, relating to Child Welfare, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Darryl Ervin Rouson
Florida Senate, District 19

File signed original with committee office

S-020 (03/2004)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/26
*Meeting Date*

S 122
*Bill Number (if applicable)*

251124
*Amendment Barcode (if applicable)*

Topic Child Welfare

Name Victoria Zepp

Job Title Chief Policy Ofcr

Address 317 E. Park Ave
*Street*

TLH FL 32301
*City* *State* *Zip*

Phone 850/524 1102

Email Victoria@flchildren.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fl Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/24/20
*Meeting Date*

122
*Bill Number (if applicable)*

251124
*Amendment Barcode (if applicable)*

Topic Child Welfare

Name Alan Abramowitz

Job Title Executive Director

Address 600 S. Calhoun St.
*Street*

Phone 850.241.3232

Tallahassee | Florda | 32311
*City* | *State* | *Zip*

Email alan.abramowitz@gal.fl.gov

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Statewide Guardian ad Litem Program

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

122
*Bill Number (if applicable)*

172158
*Amendment Barcode (if applicable)*

Topic Child Welfare

Name VICTORIA ZEPP

Job Title Chief Policy Ofc

Address 317 E. Park Ave
*Street*

Tlh FL 32301
*City* *State* *Zip*

Phone 850/561-1102

Email Victoria@flchildren

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FCC

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

122
*Bill Number (if applicable)*

617230
*Amendment Barcode (if applicable)*

Topic Child Welfare

Name Victoria Zepp

Job Title Chief Policy Ofer

Address 317 E. Park
*Street*

144 FL 32301
*City* *State* *Zip*

Phone 850/561-1102

Email Victoria@flchildren.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/2020
*Meeting Date*

CS/SB 122
*Bill Number (if applicable)*

522422
*Amendment Barcode (if applicable)*

Topic Child Welfare Certification

Name Neal McGarry

Job Title CEO

Address 1715 South Gadsden Street
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone 850-222-6314

Email namcgarry@flcertificationboard.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Certification Board

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

122
*Bill Number (if applicable)*

Topic Child Welfare

522422
*Amendment Barcode (if applicable)*

Name Victoria Zepp

Job Title Chief Policy Ofcr

Address 317 E. Park Ave
*Street*

TLH FL 32301
*City* *State* *Zip*

Phone 850/561-1102

Email Victoria@flchildren

Speaking: ☐ For ☐ Against ☑ Information

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

Representing FL Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2.25.2020
*Meeting Date*

SB 122
*Bill Number (if applicable)*

409736
*Amendment Barcode (if applicable)*

Topic Jordan's Law

Name Slater Bayliss

Job Title Lobbyist

Address 204 S Monroe Street
*Street*

Phone 850-222-8900

Tallahassee
*City*

FL
*State*

32301
*Zip*

Email swb@cardenaspartners.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Eckerd Connects

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

25 Feb 20
*Meeting Date*

122
*Bill Number (if applicable)*

Topic Child Welfare

*Amendment Barcode (if applicable)*

Name Barney Bishop III

Job Title CEO

Address 2215 Thomasville Road
*Street*

Phone 850.510.9922

Tallahassee FL 32308
*City* *State* *Zip*

Email barney@barneybishop.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Smart Justice Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 122
*Bill Number (if applicable)*

Topic SB 122

*Amendment Barcode (if applicable)*

Name Jordan Reed

Job Title Legislative Intern

Address _____ Phone _____
*Street*

_____ Email _____
*City* *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing National Association of Social Workers Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

# APPEARANCE RECORD

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

2.25.2020
*Meeting Date*

SB 122
*Bill Number (if applicable)*

409736 B-11 AS AMEND
*Amendment Barcode (if applicable)*

Topic Jordan's Law

Name Slater Bayliss

Job Title Lobbyist

Address 204 S Monroe Street
*Street*

Phone 850-222-8900

Tallahassee — FL — 32301
*City* — *State* — *Zip*

Email swb@cardenaspartners.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Eckerd Connects

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

**By** the Committee on Children, Families, and Elder Affairs; and Senators Rouson, Berman, Hooper, and Book

586-02427-20 2020122c1

A bill to be entitled

An act relating to child welfare; providing a short title; amending s. 39.202, F.S.; expanding the list of entities with access to certain records that relate to child abandonment, abuse, or neglect held by the Department of Children and Families; amending s. 39.303, F.S.; requiring Child Protection Teams to be capable of providing certain training relating to head trauma and brain injuries in children younger than a specified age; amending s. 39.401, F.S.; authorizing the parent or legal guardian of a child to request a second medical evaluation of a child under certain circumstances; requiring the court to consider such evaluation when determining whether to remove the child from the home; amending s. 39.8296, F.S.; revising the membership of the curriculum committee established to develop a specified training program; requiring the training program to include certain training relating to head trauma and brain injuries in children younger than a specified age; amending s. 402.40, F.S.; revising legislative findings and providing legislative intent; requiring the department to develop and implement a specified child welfare workforce development framework in collaboration with other specified entities; providing requirements for the department relating to workforce education requirements; requiring the department to submit an annual report to the Governor and the Legislature by a specified date; requiring community-based care lead







586-02427-20 2020122c1

agencies to submit a plan and timeline to the department relating to certain child welfare staff by a specified date; providing requirements for the department related to workforce training; providing legislative findings; requiring the department to establish an Office of Well-Being and Support; requiring the department to contract with certain university-based centers to develop and coordinate the implementation of a specified helpline; requiring the department to submit a report on the implementation of such helpline to the Governor and the Legislature on a specified date; providing additional duties for third-party credentialing entities; requiring certain attorneys employed by the department to complete certain training by a specified date; deleting definitions; deleting provisions relating to core competencies and specializations; amending s. 409.988, F.S.; requiring a lead agency to ensure that certain individuals receive specified training relating to head trauma and brain injuries in children younger than a specified age; revising the types of services a lead agency is required to provide; creating s. 943.17298, F.S.; requiring law enforcement officers to complete training relating to head trauma and brain injuries in children younger than a specified age as part of either basic recruit training or continuing training or education by a specified date; amending s. 1004.615, F.S.; revising the purpose of the Florida Institute for Child Welfare; revising requirements for

the institute; revising the contents of the annual report that the institute must provide to the Governor and the Legislature; deleting obsolete provisions; repealing s. 402.402, F.S., relating to child protection and child welfare personnel and attorneys employed by the department; amending ss. 409.996 and 1009.25, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. This act may be cited as "Jordan's Law."

Section 2. Paragraph (a) of subsection (2) of section 39.202, Florida Statutes, is amended to read:

39.202 Confidentiality of reports and records in cases of child abuse or neglect.—

(2) Except as provided in subsection (4), access to such records, excluding the name of, or other identifying information with respect to, the reporter which shall be released only as provided in subsection (5), shall be granted only to the following persons, officials, and agencies:

(a) Employees, authorized agents, or contract providers of the department, the Department of Health, the Agency for Persons with Disabilities, the Office of Early Learning, or county agencies responsible for carrying out:

1. Child or adult protective investigations;

2. Ongoing child or adult protective services;

3. Early intervention and prevention services;

4. Healthy Start services;





5. Licensure or approval of adoptive homes, foster homes, child care facilities, facilities licensed under chapter 393, family day care homes, providers who receive school readiness funding under part VI of chapter 1002, or other homes used to provide for the care and welfare of children;

6. Employment screening for caregivers in residential group homes; ~~or~~

7. Services for victims of domestic violence when provided by certified domestic violence centers working at the department's request as case consultants or with shared clients; or

8. Credentialing of child welfare services staff pursuant to s. 402.40.

Also, employees or agents of the Department of Juvenile Justice responsible for the provision of services to children, pursuant to chapters 984 and 985.

Section 3. Paragraph (h) of subsection (3) of section 39.303, Florida Statutes, is amended to read:

39.303 Child Protection Teams and sexual abuse treatment programs; services; eligible cases.—

(3) The Department of Health shall use and convene the Child Protection Teams to supplement the assessment and protective supervision activities of the family safety and preservation program of the Department of Children and Families. This section does not remove or reduce the duty and responsibility of any person to report pursuant to this chapter all suspected or actual cases of child abuse, abandonment, or neglect or sexual abuse of a child. The role of the Child

Protection Teams is to support activities of the program and to provide services deemed by the Child Protection Teams to be necessary and appropriate to abused, abandoned, and neglected children upon referral. The specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services that a Child Protection Team must be capable of providing include, but are not limited to, the following:

(h) Such training services for program and other employees of the Department of Children and Families, employees of the Department of Health, and other medical professionals as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases. The training services must include training in the recognition of and appropriate responses to head trauma and brain injury in a child under 6 years of age as required under ss. 39.8296, 402.40, and 943.17298.

A Child Protection Team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child shall consult with a physician who has experience in treating children with the same condition.

Section 4. Subsection (3) of section 39.401, Florida Statutes, is amended to read:

39.401 Taking a child alleged to be dependent into custody; law enforcement officers and authorized agents of the department.—

(3) If the child is taken into custody by, or is delivered to, an authorized agent of the department, the agent shall review the facts supporting the removal with an attorney





representing the department. The purpose of the review is to determine whether there is probable cause for the filing of a shelter petition.

(a) If the facts are not sufficient, the child shall immediately be returned to the custody of the parent or legal custodian.

(b) If the facts are sufficient and the child has not been returned to the custody of the parent or legal custodian, the department shall file the petition and schedule a hearing, and the attorney representing the department shall request that a shelter hearing be held within 24 hours after the removal of the child. While awaiting the shelter hearing, the authorized agent of the department may place the child in licensed shelter care or may release the child to a parent or legal custodian or responsible adult relative or the adoptive parent of the child's sibling who shall be given priority consideration over a licensed placement, or a responsible adult approved by the department if this is in the best interests of the child. Placement of a child which is not in a licensed shelter must be preceded by a criminal history records check as required under s. 39.0138. In addition, the department may authorize placement of a housekeeper/homemaker in the home of a child alleged to be dependent until the parent or legal custodian assumes care of the child.

(c) If the decision to remove a child from the home is predicated upon a medical evaluation performed by a Child Protection Team pursuant to s. 39.303, the parent or legal guardian of the child may request that a second, independent evaluation be performed by a physician who has met the relevant

qualifications of s. 39.303(2)(b) in order to determine whether the child has been the victim of abuse or neglect. The court must consider this evaluation when determining whether to remove a child from the home.

Section 5. Paragraph (b) of subsection (2) of section 39.8296, Florida Statutes, is amended to read:

39.8296 Statewide Guardian Ad Litem Office; legislative findings and intent; creation; appointment of executive director; duties of office.—

(2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a Statewide Guardian Ad Litem Office within the Justice Administrative Commission. The Justice Administrative Commission shall provide administrative support and service to the office to the extent requested by the executive director within the available resources of the commission. The Statewide Guardian Ad Litem Office shall not be subject to control, supervision, or direction by the Justice Administrative Commission in the performance of its duties, but the employees of the office shall be governed by the classification plan and salary and benefits plan approved by the Justice Administrative Commission.

(b) The Statewide Guardian Ad Litem Office shall, within available resources, have oversight responsibilities for and provide technical assistance to all guardian ad litem and attorney ad litem programs located within the judicial circuits.

1. The office shall identify the resources required to implement methods of collecting, reporting, and tracking reliable and consistent case data.

2. The office shall review the current guardian ad litem programs in Florida and other states.





3. The office, in consultation with local guardian ad litem offices, shall develop statewide performance measures and standards.

4. ~~The office shall develop a guardian ad litem training program.~~ The office shall establish a curriculum committee to develop a guardian ad litem ~~the~~ training program ~~specified in this subparagraph~~. The curriculum committee shall include, but not be limited to, dependency judges, directors of circuit guardian ad litem programs, active certified guardians ad litem, a mental health professional who specializes in the treatment of children, a member of a child advocacy group, a representative of the Florida Coalition Against Domestic Violence, an individual with a degree in social work, and a social worker experienced in working with victims and perpetrators of child abuse. The training program must include training in the recognition of and appropriate responses to head trauma and brain injury in a child under 6 years of age developed by the Child Protection Team Program within the Department of Health.

5. The office shall review the various methods of funding guardian ad litem programs, shall maximize the use of those funding sources to the extent possible, and shall review the kinds of services being provided by circuit guardian ad litem programs.

6. The office shall determine the feasibility or desirability of new concepts of organization, administration, financing, or service delivery designed to preserve the civil and constitutional rights and fulfill other needs of dependent children.

7. In an effort to promote normalcy and establish trust

between a court-appointed volunteer guardian ad litem and a child alleged to be abused, abandoned, or neglected under this chapter, a guardian ad litem may transport a child. However, a guardian ad litem volunteer may not be required or directed by the program or a court to transport a child.

8. The office shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court an interim report describing the progress of the office in meeting the goals as described in this section. The office shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court a proposed plan including alternatives for meeting the state's guardian ad litem and attorney ad litem needs. This plan may include recommendations for less than the entire state, may include a phase-in system, and shall include estimates of the cost of each of the alternatives. Each year the office shall provide a status report and provide further recommendations to address the need for guardian ad litem services and related issues.

Section 6. Section 402.40, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 402.40, F.S., for present text.)

402.40 Child welfare workforce; development; training; certification; well-being.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that positive outcomes for children and families involved with the child welfare system





often are attributable to the strong commitment of a well-trained, highly skilled, well-resourced, and dedicated child welfare workforce and that the child welfare system is only as good as the individuals who conduct investigations, provide services to children and families, and manage service delivery.

(b) The Legislature also finds that child welfare agencies experience barriers to establishing and maintaining a stable, effective, and diverse workforce because of issues relating to recruitment, education and training, inadequate supervision, retention and staff turnover, and lack of support for frontline individuals.

(c) The Legislature further finds that, although numerous initiatives have been developed to address these challenges, isolated interventions often fail to yield positive results, whereas implementing an integrated framework across multiple domains can help child welfare agencies achieve effective outcomes.

(d) It is the intent of the Legislature to ensure a systematic approach to child welfare workforce staff development and the well-being of individuals providing child welfare services by establishing a uniform statewide program.

(2) CHILD WELFARE WORKFORCE DEVELOPMENT FRAMEWORK.—In order to promote competency-based, outcome-focused, and data-driven approaches to workforce development, the department, in collaboration with the Florida Institute for Child Welfare, shall develop and implement a comprehensive child welfare development workforce framework using a nationally recognized model for workforce development. The framework must address, at a minimum, all of the following components:

(a) Recruitment and hiring.

(b) Education and professional preparation.

(c) Professional training and development.

(d) Supervision.

(e) Retention.

(f) Caseload and workload.

(g) Workforce well-being and support.

(h) Work-life balance and flexible scheduling.

(i) Agency culture and climate.

(3) WORKFORCE EDUCATION REQUIREMENTS.—

(a) The department shall make every effort to recruit and hire qualified professional staff to serve as child protective investigators and child protective investigation supervisors who are qualified by their education and experience to perform social work functions. The department, in collaboration with the lead agencies, subcontracted provider organizations, the Florida Institute for Child Welfare, and other partners in the child welfare system, shall develop a protocol for screening candidates for child protective positions which reflects the preferences specified in subparagraphs 1., 2., and 3. The following persons must be given preference in recruitment, but this preference serves only as guidance and does not limit the department's discretion to select the best available candidates:

1. Individuals with a baccalaureate degree in social work, and child protective investigation supervisors with a master's degree in social work, from a college or university social work program accredited by the Council on Social Work Education.

2. Individuals with a bachelor's degree or a master's degree in psychology, sociology, counseling, special education,





education, human development, child development, family development, marriage and family therapy, or nursing.

3. Individuals with baccalaureate degrees who have a combination of directly relevant work and volunteer experience, preferably in a public service field related to children's services, which demonstrates critical thinking skills, formal assessment processes, communication skills, problem solving, and empathy; a commitment to helping children and families; a capacity to work as part of a team; an interest in continuous development of skills and knowledge; and sufficient personal strength and resilience to manage competing demands and handle workplace stresses.

(b) By each October 1, the department shall submit a report on the educational qualifications, turnover, and working conditions of child protective investigators and supervisors to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(c) By January 1, 2021, the community-based care lead agencies shall submit to the department a plan and timeline for recruiting and hiring child welfare staff providing care for dependent children which meet the same educational requirements as required for child protective investigators and child protective investigation supervisors under this subsection. The plan and timeline must include the same recruiting and hiring requirements for child welfare staff employed by subcontractors.

(4) WORKFORCE TRAINING.—

(a) In order to enable the state to recruit and retain a qualified and diverse child welfare workforce that is well-trained, well-supervised, and well-supported, the department

shall establish a program for a comprehensive system to provide both preservice and inservice child welfare competency-based training that all child welfare staff, including all staff providing care for dependent children employed by a community-based care lead agency or by a subcontractor of such agency, are required to participate in and successfully complete, appropriate to their areas of responsibility. Such program must include training in the recognition of and appropriate responses to head trauma and brain injury in a child under 6 years of age, which must be developed by the Child Protection Team Program within the Department of Health.

(b) A community-based care lead agency may develop additional training for persons delivering child welfare services in the agency's service area if the curriculum does not conflict with training required in paragraph (a).

(c) By October 1, 2021, the department shall establish, maintain, and oversee the operation of at least one regional child welfare professional development center in this state. The department shall determine the number and location of, and the timeframe for establishing, additional development centers and shall contract for the operation of the centers with a public postsecondary institution pursuant to s. 402.7305.

(5) WORKFORCE WELL-BEING AND SUPPORT.—The Legislature finds that vicarious trauma, burnout, and lack of self-care can challenge all first responders, including child welfare professionals. First responders who care for others often need peer counseling, crisis support, and other resilience-building services to normalize issues and promote retention. The Legislature further finds that these activities are best





provided by those with shared life experiences who may provide assistance that traditional mental health or employee assistance programs are unable to provide.

(a) The department shall establish an Office of Well-Being and Support.

(b) The department shall contract with one or more university-based centers that have expertise in behavioral health to develop and coordinate the implementation of a helpline that is operational 24 hours per day and 7 days a week, staffed by former child welfare supervisors and caseworkers and child protective investigators, and reflective of the nationally recognized best practice reciprocal peer support model. The helpline must be capable of providing peer support, telephone assessment, and referral services.

(c) The department shall submit a report providing an update on the activities of the office and implementation of the helpline to the Governor, the President of the Senate, and the Speaker of the House of Representatives on December 1, 2020.

(6) WORKFORCE CERTIFICATION.—The department shall approve one or more third-party credentialing entities for the purpose of developing and administering child welfare certification programs for persons who provide child welfare services. A third-party credentialing entity shall request such approval in writing from the department. In order to obtain approval, the third-party credentialing entity must:

(a) Establish professional requirements and standards that applicants must achieve in order to obtain a child welfare certification and to maintain such certification.

(b) Develop and apply core competencies and examination

instruments according to nationally recognized certification and psychometric standards.

(c) Maintain a professional code of ethics and a disciplinary process that apply to all persons holding child welfare certification.

(d) Maintain a database, accessible to the public, of all persons holding child welfare certification, including any history of ethical violations.

(e) Require annual continuing education for persons holding child welfare certification and require certified professionals to comply with the training requirements in subsection (4) as a condition of renewal or initial certification. The third-party credentialing entity shall track and report compliance with this section to the department on an annual basis.

(f) Administer a continuing education provider program to ensure that only qualified providers offer continuing education opportunities for certificateholders.

(g) All certified child welfare professionals must follow the requirements of the third-party credentialing entities code of ethical and professional conduct and disciplinary procedures.

1. The department, community based care lead agencies, sheriff offices and their contracted providers shall report all allegations of suspected or known violations of ethical or professional misconduct standards to the department approved third-party credentialing entity, including all allegations made to the department's Office of Inspector General on certified personnel.

2. The third-party credentialing entity shall review all case records involving the death of a child or other critical





incident to ensure compliance with the third-party credentialing entity's published code of ethical and professional conduct and disciplinary procedures.

3. The department shall provide the third-party credentialing entity with all reports necessary to conduct a thorough investigation on all certified child welfare service providers involved with the case.

4. The third-party credentialing entity shall immediately suspend the certification of all certified individuals involved in the case pending the results of the initial review of the certified professional's role and performance as it relates to the case circumstance.

5. The department or sub-contracted employer of the certified staff must immediately remove the individual from their duties that require certification as a condition of employment until the initial review is complete and the third-party credentialing entity determines if an ethics case is warranted.

6. Any decision by a department approved credentialing entity to deny, revoke, or suspend a certification, or otherwise impose sanctions on an individual who is certified, is reviewable by the department. Upon receiving an adverse determination, the person aggrieved may request an administrative hearing pursuant to ss. 120.569 and 120.57(1) within 30 days after completing any appeals process offered by the credentialing entity or the department, as applicable.

7. The third-party credentialing entity shall track and report compliance with this subsection to the department.

(h) Maintain an advisory committee, including

representatives from each region of the department, each sheriff's office providing child protective services, and each community-based care lead agency, who shall be appointed by the organization they represent. The third-party credentialing entity may appoint additional members to the advisory committee.

(7) CHILD WELFARE TRAINING TRUST FUND.—

(a) There is created within the State Treasury a Child Welfare Training Trust Fund to be used by the Department of Children and Families for the purpose of funding the professional development of persons providing child welfare services.

(b) One dollar from every noncriminal traffic infraction collected pursuant to s. 318.14(10)(b) or s. 318.18 shall be deposited into the Child Welfare Training Trust Fund.

(c) In addition to the funds generated by paragraph (b), the trust fund shall receive funds generated from an additional fee on birth certificates and dissolution of marriage filings, as specified in ss. 382.0255 and 28.101, respectively, and may receive funds from any other public or private source.

(d) Funds that are not expended by the end of the budget cycle or through a supplemental budget approved by the department shall revert to the trust fund.

(8) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD WELFARE CASES.—With the exception of attorneys hired after July 1, 2014, but before July 1, 2020, who shall complete the training required under this subsection by January 31, 2021, attorneys hired by the department on or after July 1, 2014, whose primary responsibility is representing the department in child welfare cases shall receive training within the first 6





months of employment in:

(a) The dependency court process, including the attorney's role in preparing and reviewing documents prepared for dependency court for accuracy and completeness;

(b) Preparing and presenting child welfare cases, including at least 1 week of shadowing an experienced children's legal services attorney who is preparing and presenting cases;

(c) Safety assessment, safety decisionmaking tools, and safety plans;

(d) Developing information presented by investigators and case managers to support decisionmaking in the best interest of children; and

(e) The experiences and techniques of case managers and investigators, including shadowing an experienced child protective investigator and an experienced case manager for at least 8 hours.

(8) ADOPTION OF RULES.—The department shall adopt rules necessary to administer this section.

Section 7. Paragraph (f) of subsection (1) and subsection (3) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(f) Shall ensure that all individuals providing care for dependent children participate in and successfully complete the program of ~~receive appropriate~~ training relevant to the individual's area of responsibility and meet the minimum employment standards established by the department pursuant to s. 402.40. The training curriculum must include training in the recognition of and appropriate responses to head trauma and

brain injury in a child under 6 years of age developed by the Child Protection Team Program within the Department of Health.

(3) SERVICES.—A lead agency must provide dependent children with services that are supported by research or that are recognized as best practices in the child welfare field. The agency shall give priority to the use of services that are evidence-based and trauma-informed and may also provide other innovative services, including, but not limited to, family-centered and cognitive-behavioral interventions designed to mitigate out-of-home placements and intensive family reunification services that combine child welfare and mental health services for families with dependent children under 6 years of age.

Section 8. Section 943.17298, Florida Statutes, is created to read:

943.17298 Training in the recognition of and responses to head trauma and brain injury.—Each law enforcement officer must successfully complete training on the subject of the recognition of and appropriate responses to head trauma and brain injury in a child under 6 years of age developed by the Child Protection Team Program within the Department of Health to aid an officer in the detection of head trauma and brain injury due to child abuse. Such training must be completed as part of the basic recruit training for a law enforcement officer, as required under s. 943.13(9), or as a part of continuing training or education required under s. 943.135(1), before July 1, 2022.

Section 9. Section 1004.615, Florida Statutes, is amended to read:

1004.615 Florida Institute for Child Welfare.—





(1) There is established the Florida Institute for Child Welfare within the Florida State University College of Social Work. The purpose of the institute is to advance the well-being of children and families who are involved with, or at risk of becoming involved with, the child welfare system by facilitating and supporting statewide partnerships to develop competency-based education, training, and support to prepare a diverse group of social work professionals for careers in child welfare ~~by improving the performance of child protection and child welfare services through research, policy analysis, evaluation, and leadership development~~. The institute shall consist of a consortium of public and private universities offering degrees in social work and shall be housed within the Florida State University College of Social Work.

(2) Using such resources as authorized in the General Appropriations Act, the Department of Children and Families shall collaborate ~~contract~~ with the institute for performance of the duties described in subsection (3) ~~(4)~~ using state appropriations, public and private grants, and other resources obtained by the institute.

(3) In order to increase and retain a higher percentage of professionally educated social workers in the child welfare system and serve as a statewide resource for child welfare workforce education and training, the institute, in collaboration with the Department of Children and Families, shall:

(a) Design and disseminate a continuum of social work education and training which emphasizes child welfare workforce stabilization and professionalization by aligning social work

curriculum and training with critical practice skills pursuant to s. 402.40.

(b) Identify methods to promote continuing professional development and systems of workplace support for existing child welfare staff.

(c) Develop a best practice model for providing feedback on curriculum to social work programs and for ensuring that interns who will be entering the child welfare profession are well-supervised by university personnel during their internships.

(d) Create a Title IV-E program designed to provide professional education and monetary support to undergraduate and graduate social work students who intend to pursue or continue a career in child welfare. Goals of the program should include:

1. Increasing the number of individuals in the child welfare workforce who have a bachelor's degree or master's degree in social work.

2. Prioritizing the enrollment of current child welfare staff employed by the state.

3. Prioritizing the enrollment of students who reflect the diversity of the state's child welfare population.

4. Providing specific program support through the provision of specialized competency-based child welfare curriculum and monetary support to students.

(e) Engage in evaluation and dissemination of evidence-based and promising practices in child welfare and build high-quality evaluation into new program models and pilots.

The institute shall also provide consultation on the creation of the Office of Well-Being and Support within the Department of







Children and Families pursuant to s. 402.40 ~~The institute shall work with the department, sheriffs providing child protective investigative services, community-based care lead agencies, community-based care provider organizations, the court system, the Department of Juvenile Justice, the Florida Coalition Against Domestic Violence, and other partners who contribute to and participate in providing child protection and child welfare services~~.

(4) ~~The institute shall:~~

~~(a) Maintain a program of research which contributes to scientific knowledge and informs both policy and practice related to child safety, permanency, and child and family well-being.~~

~~(b) Advise the department and other organizations participating in the child protection and child welfare system regarding scientific evidence on policy and practice related to child safety, permanency, and child and family well-being.~~

~~(c) Provide advice regarding management practices and administrative processes used by the department and other organizations participating in the child protection and child welfare system and recommend improvements that reduce burdensome, ineffective requirements for frontline staff and their supervisors while enhancing their ability to effectively investigate, analyze, problem solve, and supervise.~~

~~(d) Assess the performance of child protection and child welfare services based on specific outcome measures.~~

~~(e) Evaluate the scope and effectiveness of preservice and inservice training for child protection and child welfare employees and advise and assist the department in efforts to~~

~~improve such training.~~

~~(f) Assess the readiness of social work graduates to assume job responsibilities in the child protection and child welfare system and identify gaps in education which can be addressed through the modification of curricula or the establishment of industry certifications.~~

~~(g) Develop and maintain a program of professional support including training courses and consulting services that assist both individuals and organizations in implementing adaptive and resilient responses to workplace stress.~~

~~(h) Participate in the department's critical incident response team, assist in the preparation of reports about such incidents, and support the committee review of reports and development of recommendations.~~

~~(i) Identify effective policies and promising practices, including, but not limited to, innovations in coordination between entities participating in the child protection and child welfare system, data analytics, working with the local community, and management of human service organizations, and communicate these findings to the department and other organizations participating in the child protection and child welfare system.~~

~~(j) Develop a definition of a child or family at high risk of abuse or neglect. Such a definition must consider characteristics associated with a greater probability of abuse and neglect.~~

~~(5)~~ The President of the Florida State University shall appoint a director of the institute. The director must be a child welfare professional with a degree in social work who







holds a faculty appointment in the Florida State University College of Social Work. The institute shall be administered by the director, and the director's office shall be located at the Florida State University. The director is responsible for overall management of the institute and for developing and executing the work of the institute consistent with the responsibilities in subsection (3) ~~(4)~~. The director shall engage individuals in other state universities with accredited colleges of social work to participate in the institute. Individuals from other university programs relevant to the institute's work, including, but not limited to, economics, management, law, medicine, and education, may also be invited by the director to contribute to the institute. The universities participating in the institute shall provide facilities, staff, and other resources to the institute to establish statewide access to institute programs and services.

(5) ~~(6)~~ By each October 1 ~~of each year~~, the institute shall provide a written report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which outlines its activities in the preceding year, reports significant research findings, as well as results of other programs, and provides specific recommendations for improving education, training, and support for individuals in the child welfare workforce ~~child protection and child welfare services~~.

~~(a) The institute shall include an evaluation of the results of the educational and training requirements for child protection and child welfare personnel established under this act and recommendations for application of the results to child protection personnel employed by sheriff's offices providing~~

~~child protection services in its report due October 1, 2017.~~

~~(b) The institute shall include an evaluation of the effects of the other provisions of this act and recommendations for improvements in child protection and child welfare services in its report due October 1, 2018.~~

~~(7) The institute shall submit a report with recommendations for improving the state's child welfare system. The report shall address topics including, but not limited to, enhancing working relationships between the entities involved in the child protection and child welfare system, identification of and replication of best practices, reducing paperwork, increasing the retention of child protective investigators and case managers, and caring for medically complex children within the child welfare system, with the goal of allowing the child to remain in the least restrictive and most nurturing environment. The institute shall submit an interim report by February 1, 2015, and final report by October 1, 2015, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 10. Section 402.402, Florida Statutes, is repealed.

Section 11. Subsection (9) of section 409.996, Florida Statutes, is amended to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that services are delivered in







accordance with applicable federal and state statutes and regulations.

(9) The department shall develop, in cooperation with the lead agencies~~, a third-party credentialing entity approved pursuant to s. 402.40(3),~~ and the Florida Institute for Child Welfare established pursuant to s. 1004.615, a standardized competency-based curriculum for certification training for child protection staff.

Section 12. Paragraph (h) of subsection (1) of section 1009.25, Florida Statutes, is amended to read:

1009.25 Fee exemptions.—

(1) The following students are exempt from the payment of tuition and fees, including lab fees, at a school district that provides workforce education programs, Florida College System institution, or state university:

(h) Pursuant to s. 402.403, child protection and child welfare personnel ~~as defined in s. 402.402~~ who are enrolled in an accredited bachelor's degree or master's degree in social work program, provided that the student attains at least a grade of "B" in all courses for which tuition and fees are exempted.

Section 13. This act shall take effect July 1, 2020.

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LEGISLATIVE ACTION

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Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 179 - 221

and insert:

Section 5. Section 39.820, Florida Statutes, is amended to read:

39.820 Definitions.—As used in this chapter ~~part~~, the term:

(1) "Guardian ad litem" as referred to in any civil or criminal proceeding includes the following: the Statewide Guardian Ad Litem Office, which includes circuit ~~a certified~~

 251124

guardian ad litem programs; ~~program,~~ a duly certified volunteer, a staff member, a staff attorney, a contract attorney, or a ~~certified~~ pro bono attorney working on behalf of a guardian ad litem ~~or the program; staff members of a program office~~; a court-appointed attorney; or a responsible adult who is appointed by the court to represent the best interests of a child in a proceeding as provided for by law, including, but not limited to, this chapter, who is a party to any judicial proceeding as a representative of the child, and who serves until discharged by the court.

(2) "Guardian advocate" means a person appointed by the court to act on behalf of a drug dependent newborn under ~~pursuant to the provisions of~~ this part.

Section 6. Paragraph (b) of subsection (2) of section 39.8296, Florida Statutes, is amended to read:

39.8296 Statewide Guardian Ad Litem Office; legislative findings and intent; creation; appointment of executive director; duties of office.—

(2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a Statewide Guardian Ad Litem Office within the Justice Administrative Commission. The Justice Administrative Commission shall provide administrative support and service to the office to the extent requested by the executive director within the available resources of the commission. The Statewide Guardian Ad Litem Office is ~~shall~~ not ~~be~~ subject to control, supervision, or direction by the Justice Administrative Commission in the performance of its duties, but the employees of the office are ~~shall be~~ governed by the classification plan and salary and benefits plan approved by the Justice Administrative Commission.

 251124

(b) The Statewide Guardian Ad Litem Office shall, within available resources, have oversight responsibilities for and provide technical assistance to all guardian ad litem and attorney ad litem programs located within the judicial circuits.

1. The office shall identify the resources required to implement methods of collecting, reporting, and tracking reliable and consistent case data.

2. The office shall review the current guardian ad litem programs in Florida and other states.

3. The office, in consultation with local guardian ad litem offices, shall develop statewide performance measures and standards.

4. The office shall develop a guardian ad litem training program, which shall include, but not be limited to, training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age. The office shall establish a curriculum committee to develop the training program specified in this subparagraph. The curriculum committee shall include, but not be limited to, dependency judges, directors of circuit guardian ad litem programs, active certified guardians ad litem, a mental health professional who specializes in the treatment of children, a member of a child advocacy group, a representative of a domestic violence advocacy group ~~the Florida Coalition Against Domestic Violence~~, and a social worker experienced in working with victims and perpetrators of child abuse.

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

And the title is amended as follows:

Delete lines 15 - 20

and insert:

child from the home; amending s. 39.820, F.S.; revising the definition of the terms "guardian ad litem" and "guardian advocate"; amending s. 39.8296, F.S.; requiring that the guardian ad litem training program include training on the recognition of and responses to head trauma and brain injury in specified children; amending s.

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LEGISLATIVE ACTION

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Appropriations Subcommittee on Health and Human Services (Harrell) recommended the following:

**Senate Amendment**

Delete line 351

and insert:

training curricula that all child welfare staff, including all staff

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LEGISLATIVE ACTION

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Appropriations Subcommittee on Health and Human Services (Harrell) recommended the following:

**Senate Amendment**

Delete lines 364 - 370.

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LEGISLATIVE ACTION

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| 02/25/2020 | . | |
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Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 371 - 509

and insert:

(5) WORKFORCE CERTIFICATION.—The department shall approve one or more third-party credentialing entities for the purpose of developing and administering child welfare certification programs for persons who provide child welfare services. A third-party credentialing entity shall request such approval in writing from the department. In order to obtain approval, the



third-party credentialing entity must:

(a) Establish professional requirements and standards that applicants must achieve in order to obtain a child welfare certification and to maintain such certification.

(b) Develop and apply core competencies and examination instruments according to nationally recognized certification and psychometric standards.

(c) Maintain a professional code of ethics and a disciplinary process that apply to all persons holding child welfare certification.

(d) Maintain a database, accessible to the public, of all persons holding child welfare certification, including any history of ethical violations.

(e) Require annual continuing education for persons holding child welfare certification and require certified professionals to comply with the training requirements in subsection (4) as a condition of renewal or initial certification. The third-party credentialing entity shall track and report compliance with this section to the department on an annual basis.

(f) Administer a continuing education provider program to ensure that only qualified providers offer continuing education opportunities for certificateholders.

(g) All certified child welfare professionals must follow the requirements of the third-party credentialing entities code of ethical and professional conduct and disciplinary procedures.

1. The department, community based care lead agencies, sheriff offices and their contracted providers shall report all allegations of suspected or known violations of ethical or professional misconduct standards to the department approved



third-party credentialing entity, including all allegations made to the department's Office of Inspector General on certified personnel.

2. The third-party credentialing entity shall review all case records involving the death of a child or other critical incident to ensure compliance with the third-party credentialing entity's published code of ethical and professional conduct and disciplinary procedures.

3. The department shall provide the third-party credentialing entity with all reports necessary to conduct a thorough investigation on all certified child welfare service providers involved with the case.

4. The third-party credentialing entity shall immediately suspend the certification of all certified individuals involved in the case pending the results of the initial review of the certified professional's role and performance as it relates to the case circumstance.

5. The department or sub-contracted employer of the certified staff must immediately remove the individual from their duties that require certification as a condition of employment until the initial review is complete and the third-party credentialing entity determines if an ethics case is warranted.

6. Any decision by a department approved credentialing entity to deny, revoke, or suspend a certification, or otherwise impose sanctions on an individual who is certified, is reviewable by the department. Upon receiving an adverse determination, the person aggrieved may request an administrative hearing pursuant to ss. 120.569 and 120.57(1)

522422

within 30 days after completing any appeals process offered by the credentialing entity or the department, as applicable.

7. The third-party credentialing entity shall track and report compliance with this subsection to the department.

(h) Maintain an advisory committee, including representatives from each region of the department, each sheriff's office providing child protective services, and each community-based care lead agency, who shall be appointed by the organization they represent. The third-party credentialing entity may appoint additional members to the advisory committee.

(6) CHILD WELFARE TRAINING TRUST FUND.—

(a) There is created within the State Treasury a Child Welfare Training Trust Fund to be used by the Department of Children and Families for the purpose of funding the professional development of persons providing child welfare services.

(b) One dollar from every noncriminal traffic infraction collected pursuant to s. 318.14(10)(b) or s. 318.18 shall be deposited into the Child Welfare Training Trust Fund.

(c) In addition to the funds generated by paragraph (b), the trust fund shall receive funds generated from an additional fee on birth certificates and dissolution of marriage filings, as specified in ss. 382.0255 and 28.101, respectively, and may receive funds from any other public or private source.

(d) Funds that are not expended by the end of the budget cycle or through a supplemental budget approved by the department shall revert to the trust fund.

(7) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD WELFARE CASES.—With the exception of attorneys hired after July

522422

1, 2014, but before July 1, 2020, who shall complete the training required under this subsection by January 31, 2021, attorneys hired by the department on or after July 1, 2014, whose primary responsibility is representing the department in child welfare cases shall receive training within the first 6 months of employment in:

(a) The dependency court process, including the attorney's role in preparing and reviewing documents prepared for dependency court for accuracy and completeness;

(b) Preparing and presenting child welfare cases, including at least 1 week of shadowing an experienced children's legal services attorney who is preparing and presenting cases;

(c) Safety assessment, safety decisionmaking tools, and safety plans;

(d) Developing information presented by investigators and case managers to support decisionmaking in the best interest of children; and

(e) The experiences and techniques of case managers and investigators, including shadowing an experienced child protective investigator and an experienced case manager for at least 8 hours.

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

And the title is amended as follows:

Delete lines 33 - 35

and insert:

department related workforce training; providing additional duties for third-

412980

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

**Senate Amendment**

Delete lines 608 - 610

and insert:

~~The institute shall~~

894626

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 718 - 733.

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

And the title is amended as follows:

Delete line 64

and insert:

employed by the department; amending s.

409736

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

**Senate Amendment (with directory and title amendments)**

Between lines 733 and 734

insert:

(24) The department, in collaboration with the lead agencies serving the judicial circuits selected in paragraph (a), may create and implement a program to more effectively provide case management services for dependent children under 6 years of age.

(a) If the program is created, the department shall select

409736

up to three judicial circuits in which to develop and implement the program, with priority given to a circuit that has a high removal rate, significant case management turnover rate, and the highest numbers of children in out-of-home care or a significant increase in the number of children in out-of-home care over the last 3 fiscal years.

(b) If the program is created, it must do each of the following:

1. Include caseloads for dependency case managers comprised solely of children who are under 6 years of age, except as provided in paragraph (c). The maximum caseload for a case manager shall be no more than 15 children, if possible.

2. Include case managers who are trained specifically in:

a. Critical child development for children under 6 years of age;

b. Specific practices of child care for children under 6 years of age;

c. The scope of community resources available to children under 6 years of age; and

d. Working with a parent or caregiver and assisting him or her in developing the skills necessary to care for the health, safety, and well-being of a child under 6 years of age.

(c) If a child being served through the program has a dependent sibling, the sibling may be assigned to the same case manager as the child being served through the program; however, each sibling counts toward the case manager's maximum caseload as provided under paragraph (b).

(d) If the program is created, the department shall evaluate the permanency, safety, and well-being of children

409736

being served through the program and submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2025, detailing its findings.

====== D I R E C T O R Y  C L A U S E  A M E N D M E N T ======
And the directory clause is amended as follows:
Delete line 719
and insert:
Statutes, is amended, and subsection (24) is added to that section, to read:

================ T I T L E  A M E N D M E N T ================
And the title is amended as follows:
Delete line 64
and insert:
employed by the department; amending s. 409.996, F.S.; conforming a provision to changes made by the act; authorizing the department and certain lead agencies to create and implement a program to more effectively provide case management services to specified children; providing criteria for selecting judicial circuits for implementation of the program; specifying requirements of the program; requiring the department to submit a report to the Governor and the Legislature by a specified date under specified conditions; amending s.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 714 |
| INTRODUCER: | Health Policy Committee and Senator Hutson |
| SUBJECT: | Testing for and Treatment of Influenza |
| DATE: | February 24, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Rossitto-Van Winkle | Brown | HP | **Fav/CS** |
| 2. | Howard | Kidd | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 714 amends the definition of the "practice of the profession of pharmacy" to include the testing for and treatment of influenza by a pharmacist under a written protocol with a primary care supervising physician that includes specific terms and conditions.

The bill authorizes a pharmacist to test for and treatment influenza, if the pharmacist:

- Completes a certification program with specific requirements approved by the Board of Medicine (BOM), in consultation with the Board of Osteopathic Medicine (BOOM) and the Board of Pharmacy (BOP), that must be developed and implemented within 90 days after the bill's effective date;
- Uses a specific instrument and a waived test;
- Uses a specific testing system that meets certain criteria;
- Obtains a complete medical history on a BOM-approved form;
- Provides pharmacy signage recommending follow-up for patients tested;
- Provides the patient with the name and contact information of the pharmacist's supervising physician;
- Provides the patient with a BOM-approved pamphlet or brochure that includes advising the patient:
  - To seek follow-up care if the test is positive; and
  - That the pharmacist and pharmacy are liable for damages from adverse reactions to the treatment;

- Treats patients only with medications approved by the BOM and reviewed annually;
- Reviews the patient's prescription history for contraindications;
- Maintains at least $250,000 of professional liability insurance; and
- Maintains, and makes available, medical records for five years using prescribed standards.

The bill also specifies certain persons whom a pharmacist may not test or treat for influenza and that a supervising physician may not supervise pharmacists employed at more than four pharmacy locations.

The Department of Health (department) will experience an increase in workload and costs associated with the requirements of the bill; however, the department anticipates existing resources are adequate to absorb the impact of the bill.

The bill includes language that implementation of the Board of Medicine's (BOM) efforts to carry out the duties required by the bill is contingent upon the enactment of an appropriation within the General Appropriations Act.

The bill takes effect upon becoming a law.

## II. Present Situation:

### The Practice of Pharmacy

Pharmacy is the third largest health profession behind nursing and medicine.[1] The Board of Pharmacy (BOP), in conjunction with the Department of Health (department), regulates the practice of pharmacists and pharmacies pursuant to ch. 465, F.S.[2] There are seven types of pharmacies eligible for various operating permits issued by the department:

- Community pharmacy;
- Institutional pharmacy;[3]
- Nuclear pharmacy;[4]
- Special pharmacy;[5]
- Internet pharmacy;[6]

[1] American Association of Colleges of Pharmacy, *About AACP*, available at https://www.aacp.org/about-aacp (last visited Feb. 13, 2020).
[2] Sections 465.004 and 465.005, F.S.
[3] *See* ss. 465.003(11)(a)2. and 465.019, F.S.
[4] The term "nuclear pharmacy" includes every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. The term "nuclear pharmacy" does not include hospitals licensed under ch. 395, F.S., or the nuclear medicine facilities of such hospitals. *See* ss. 465.003(11)(a)3. and 465.0193, F.S.
[5] The term "special pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold if such locations are not otherwise defined in this subsection. *See* ss. 465.003(11)(a)4. and 465.0196, F.S.
[6] The term "internet pharmacy" includes locations not otherwise licensed or issued a permit under this chapter, within or outside this state, which use the Internet to communicate with or obtain information from consumers in this state and use such communication or information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state. *See* ss. 465.003(11)(a)5. and 465.0197, F.S.

- Non-resident sterile compounding pharmacy;[7] and
- Special sterile compounding pharmacy.[8]

**Pharmacist Licensure**

To be licensed as a pharmacist in Florida, a person must:[9]
- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;[10]
- Have completed a BOP-approved internship; and
- Successfully complete the BOP-approved examination.

A pharmacist must complete at least 30 hours of BOP-approved continuing education during each biennial renewal period.[11] Pharmacists who are certified to administer vaccines or epinephrine autoinjections must complete a three-hour continuing education course on the safe and effective administration of vaccines and epinephrine injections as a part of the biennial licensure renewal.[12] Pharmacists who administer long-acting antipsychotic medications must complete an approved eight-hour continuing education course as a part of the continuing education for biennial licensure renewal.[13]

**Pharmacist Scope of Practice**

In Florida, the practice of the profession of pharmacy includes:[14]
- Compounding, dispensing, and consulting concerning the contents, therapeutic values, and uses of a medicinal drug;
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations;
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy, including the review of the patient's drug therapy and communication with the patient's prescribing health care provider or other persons specifically authorized by the patient, regarding the drug therapy;
- Transmitting information from prescribers to their patients;

[7] The term "nonresident sterile compounding pharmacy" includes a pharmacy that ships, mails, delivers, or dispenses, in any manner, a compounded sterile product into Florida, a nonresident pharmacy registered under s. 465.0156, F.S., or an outsourcing facility, must hold a nonresident sterile compounding permit *See* s. 465.0158, F.S.
[8] *See* Fla. Admin. Code R. 64B16-2.100 and 64B16-28.802 (2019). An outsourcing facility is considered a pharmacy and needs to hold a special sterile compounding permit if it engages in sterile compounding.
[9] Section 465.007, F.S. The department may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[10] If the applicant has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, the applicant must demonstrate proficiency in English, pass the board-approved Foreign Pharmacy Graduate Equivalency Examination, and complete a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a department-licensed pharmacist.
[11] Section 465.009, F.S.
[12] Section 465.009(6), F.S.
[13] Section 465.1893, F.S.
[14] Section 465.003(13), F.S.

- Preparing prepackaged drug products in facilities holding Class III institutional facility permits;[15]
- Administering vaccines to adults;[16]
- Administering epinephrine injections;[17] and
- Administering antipsychotic medications by injection.[18]

A pharmacist may not alter a prescriber's directions, diagnosing or treating any disease, initiating any drug therapy, and practicing medicine or osteopathic medicine, unless permitted by law.[19]

Pharmacists may order and dispense drugs that are included in a formulary developed by a committee composed of members of the Boards of Medicine (BOM), Board of Osteopathic Medicine (BOOM), and the BOP.[20] The formulary may only include:[21]

- Medicinal drugs of single or multiple active ingredients in any strengths when such active ingredients have been approved individually or in combination for over-the-counter sale by the U.S. Food and Drug Administration (FDA);
- Medicinal drugs recommended by the FDA's Advisory Panel for transfer to over-the-counter status pending approval by the FDA;
- Medicinal drugs containing an antihistamine or decongestant as a single active ingredient or in combination;
- Medicinal drugs containing fluoride in any strength;
- Medicinal drugs containing lindane in any strength;
- Over-the-counter proprietary drugs under federal law that have been approved for reimbursement by the Florida Medicaid Program; and
- Topical anti-infectives, excluding eye and ear topical anti-infectives.

A pharmacist may order, within his or her professional judgment and subject to the stated conditions:[22]

- Certain oral analgesics for mild to moderate pain. The pharmacist may order these drugs for minor pain and menstrual cramps for patients with no history of peptic ulcer disease. The prescription is limited to a six day supply for one treatment:
  - Magnesium salicylate/phenyltoloxamine citrate;
  - Acetylsalicylic acid (Zero order release, long acting tablets);
  - Choline salicylate and magnesium salicylate;
  - Naproxen sodium;
  - Naproxen;
  - Ibuprofen;
  - Phenazopyridine, for urinary pain; and

[15] A Class III institutional pharmacy are those pharmacies affiliated with a hospital. *See* s. 465.019(2)(d), F.S.
[16] *See* s. 465.189, F.S.
[17] *Id.*
[18] Section 465.1893, F.S.
[19] Section 465.003(13), F.S.
[20] Section 465.186, F.S.
[21] Id.
[22] Fla. Admin. Code R. 64B16-27.220, (2019).

  - Antipyrine 5.4%, benzocaine 1.4%, glycerin, for ear pain if clinical signs or symptoms of tympanic membrane perforation are not present;
- Anti-nausea preparations;
- Certain antihistamines and decongestants;
- Certain topical antifungal/antibacterial;
- Topical anti-inflammatory preparations containing hydrocortisone not exceeding 2.5%;
- Otic antifungal/antibacterial;
- Salicylic acid 16.7% and lactic acid 16.7% in flexible collodion, to be applied to warts, except for patients under 2 years of age, and those with diabetes or impaired circulation;
- Vitamins with fluoride, excluding vitamins with folic acid in excess of 0.9 mg.;
- Medicinal drug shampoos containing Lindane for the treatment of head lice;
- Ophthalmics. Naphazoline 0.1% ophthalmic solution;
- Certain histamine H2 antagonists;
- Acne products; and
- Topical Antiviral for herpes simplex infections of the lips.[23]

One category of pharmacist has a broader scope of practice then other pharmacists. A consultant pharmacist, also known as a senior care pharmacist, provides expert advice on the use of medications to individuals or older adults, wherever they live.[24] In addition to the training and education received as a part of a degree program in pharmacy, a consultant pharmacist must complete a consultant pharmacy course and a period of assessment and evaluation under the supervision of a preceptor.[25]

A consultant pharmacist may order and evaluate laboratory testing in addition to the services provided by a pharmacist. For example, a consultant pharmacist can order and evaluate clinical and laboratory testing for a patient residing in a nursing home upon authorization by the medical director of the nursing home.[26] Additionally, a consultant pharmacist may order and evaluate clinical and laboratory testing for individuals under the care of a licensed home health agency, if authorized by a licensed physician, podiatrist, or dentist.[27]

**Pharmacist Administration of Vaccines and Injections**

A pharmacist may become certified to administer the immunizations or vaccines listed in the Centers for Disease Prevention and Control (CDC) Adult Immunization Schedule as of February 1, 2015, as well as those recommended for international travel as of July 1, 2015.[28] To be certified to administer vaccines, a pharmacist must:

[23] Fla. Admin. Code R. 64B16-27.220 (2019).
[24] American Society of Consultant Pharmacists, *What is a Consultant Pharmacist,* available at http://www.ascp.com/page/whatisacp (last visited Feb. 13, 2020).
[25] Fla. Admin. Code R. 64B16-26.300(3), (2019).
[26] Section 465.0125(1), F.S.
[27] Section 465.0125(2), F.S. To qualify to order and evaluate such testing, the consultant pharmacist or doctor of pharmacy must complete 3 hours of board-approved training, related to laboratory and clinical testing.
[28] Section 465.189, F.S. A registered intern may also administers immunizations or vaccinations under the supervision of a certified pharmacist.

- Enter into a written protocol under a supervising physician licensed under ch. 458, or ch. 459, F.S.;[29] which must:[30]
  - Specify the categories and conditions among patients to whom the pharmacist may administer such vaccines;
  - Be appropriate to the pharmacist's training and certification for administering such vaccine;
  - Outline the process and schedule for the review of the administration of vaccines by the pharmacists pursuant to the written protocol; and
  - Be submitted to the BOP;
- Successfully complete a BOP-approved vaccine administration certification program that consists of at least 20 hours of continuing education;[31]
- Pass an examination and demonstrate vaccine administration technique;[32]
- Must maintain and make available patient records using the same standards for confidentiality and maintenance of such records as required by s. 456.057, F.S., and maintain the records for at least five years;[33] and
- Maintain at least $200,000 of professional liability insurance.[34]

A pharmacist may also administer epinephrine using an autoinjector delivery system, within the framework of the established protocol with the supervising physician, to treat any allergic reaction resulting from a vaccine.[35] A pharmacist administering vaccines must provide the department with vaccination records for inclusion in the state's registry of immunization information.[36]

**Pharmacist Administration of Antipsychotic Medication by Injection**

In 2017, the Legislature authorized a licensed pharmacist to administer an injection of a long-acting antipsychotic medication[37] approved by the United States Food and Drug Administration.[38] To be eligible to administer such injections, a pharmacist must:[39]

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[29] Section 465.189(1), F.S.
[30] Section 465.189(7), F.S.
[31] Section 465.189(6), F.S., Fla. Admin. Code R. 64B16-26.1031,(2019), provides more detail regarding subject matter that must be included in the certification course.
[32] Id.
[33] Section 456.057, F.S., requires certain health care practitioners to develop and implement policies, standards, and procedures to protect the confidentiality and security of medical records, provides conditions under which a medical record may be disclosed without the express consent of the patient, provides procedures for disposing of records when a practice is closing or relocating, and provides for enforcement of its provisions.
[34] Section 465.189(3), F.S.
[35] Section 465.189(2), F.S.
[36] Section 465.189(5), F.S.
[37] A long-acting injectable antipsychotic medication may be prescribed to treat symptoms of psychosis associated with schizophrenia or as a mood stabilizer in individuals with bipolar disorder. A long-acting injectable may last from two to 12 weeks. It may be prescribed for individuals who have difficulty remembering to take daily medications or who have a history of discontinuing medication. National Alliance on Mental Illness, *Long-Acting Injectables*, available at https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Long-Acting-Injectables (last visited Feb 13, 2020).
[38] Chapter 2017-134, Laws of Fla., codified at s. 465.1893, F.S.
[39] Id.

- Be authorized by and acting within the framework of a protocol with the prescribing physician;
- Practice at a facility that accommodates privacy for nondeltoid injections and conforms with state rules and regulations for the appropriate and safe disposal of medication and medical waste;[40] and
- Complete an approved eight-hour continuing education course that includes instruction on the safe and effective administration of behavioral health and antipsychotic medications by injection, including potential allergic reactions.

A separate prescription from a physician is required for each injection a pharmacist administers.[41]

**Diagnostic Tests for Influenza and Streptococcus**

***Influenza***

Influenza (flu) is a contagious viral respiratory illness that infects the nose, throat, and sometimes the lungs. It can cause mild to severe illness, and at times can lead to death. [42] There are four types of flu virus: Types A, B, C, and D. The influenza A and B viruses are responsible for seasonal flu epidemics each year.[43] Influenza type C infections generally cause mild illness and are not thought to cause human flu epidemics. Influenza D viruses primarily affect cattle and are not known to infect or cause illness in people. Influenza A viruses are the only influenza viruses known to cause flu pandemics, i.e., global epidemics of flu disease.[44]

***Flu Symptoms***

Flu is different from a cold. Flu usually comes on suddenly. People who have flu often feel some, or all, of these symptoms:

- Fever or feeling feverish/chills;
- Cough;
- Sore throat;
- Runny or stuffy nose;
- Muscle or body aches;
- Headaches;
- Fatigue (tiredness); and

Some people may have vomiting and diarrhea, though this is more common in children than adults.[45]

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[40] Section 381.0098, F.S., and Fla. Admin. Code R. 64E-16, (2019), regulate the disposal of biomedical waste.
[41] Section 465.1893(1)(b), F.S.
[42] Centers for Disease Control and Prevention, *Key Facts about Influenza (Flu)*, (last reviewed July 10, 2019) *available at* https://www.cdc.gov/flu/about/keyfacts.htm (last visited Feb 13, 2020).
[43] Center for Disease Control and Prevention, *Influenza (Flu)*, available at https://www.cdc.gov/flu/about/viruses/index.htm (last visited Feb. 13, 2020).
[44] Center for Disease Control and Prevention, *Types of Influenza Viruses*, (November 18, 2019) *available at* https://www.cdc.gov/flu/about/viruses/types.htm (last visited Feb. 13, 2020).
[45] See note 43. It's important to note that not everyone with flu will have a fever.

***Flu Complications***

Most people who get the flu will recover in a few days to less than two weeks, but some people will develop moderate complications as a result of flu, including:

- Ear infections;
- Sinus infections; and
- Worsening of chronic medical conditions, such as:
  - Congestive heart failure;
  - Asthma; or
  - Diabetes.[46]

Serious complications can also be triggered by flu and can cause:

- Heart inflammation (myocarditis);
- Brain inflammation (encephalitis);
- Muscle tissue inflammation (myositis, rhabdomyolysis);
- Multi-organ failure ( respiratory and kidney failure); and
- Death.[47]

Most people who get sick with flu will have a mild illness, will not need medical care or antiviral drugs, and will recover in less than two weeks. However people with the following health and age factors are at a higher risk of experiencing serious flu complications:

- Adults 65 years and older;
- Children younger than two years old;
- Pregnant women and women up to two weeks after the end of pregnancy;
- American Indians and Alaska Natives;
- People who live in nursing homes and other long-term care facilities;
- People who are obese with a body mass index (BMI) of 40 or higher;
- People younger than 19 years of age on long-term aspirin or salicylate medications;
- People with a weakened immune system due to disease (HIV, some cancers like leukemia) or medications (such as those receiving chemotherapy or radiation treatment for cancer, or persons with chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system);
- People with:
  - Asthma;
  - Neurologic and neurodevelopment conditions;
  - Blood disorders (such as sickle cell disease);
  - Chronic lung disease (chronic obstructive pulmonary disease and cystic fibrosis);
  - Endocrine disorders (such as diabetes mellitus);
  - Heart disease (congenital heart disease, congestive heart failure and coronary artery disease);
  - Kidney disorders;
  - Liver disorders; and

[46] Center for Disease Control and Prevention, *Flu Symptoms & Complications*, (September 18, 2019) *available at* https://www.cdc.gov/flu/symptoms/symptoms.htm (last visited Feb. 13, 2020).
[47] Id.

- Metabolic disorders (inherited metabolic disorders and mitochondrial disorders).[48]

***Diagnostic Tests for Flu***

In recent years, the FDA has approved several rapid influenza diagnostic tests (RIDTs) to identify the influenza A and B virus nucleoprotein antigens in respiratory specimens and display the result as either positive or negative. These tests can provide results within approximately 15 minutes and may be used to help with diagnosis and treatment decisions for patients. Some RIDTs use an analyzer reader device to standardize the result interpretations. However, a variety of factors can influence the accuracy of a RIDT, including the type of specimen tested, time from illness onset to collection of respiratory specimen for testing, and the prevalence of flu activity in the area. False positive results are more likely at the beginning or end of the flu season or during the summer. False negative results are more likely at the peak of the flu season.[49]

Rapid molecular assays are a new tests available to detect influenza virus infection and include the Reverse Transcription-Polymerase Chain Reaction (RT-PCR) test, and other nucleic acid amplification tests. These tests can detect influenza viral ribonucleic acid (RNA) or nucleic acids in respiratory specimens with high sensitivity and high specificity, but the detection does not necessarily indicate a live virus or ongoing viral replication. Rapid molecular assays can provide results in approximately 15-30 minutes. These tests are more accurate than RIDTs and the Infectious Diseases Society of America recommends the rapid molecular assays over RIDT for detecting the flu virus in outpatients. As with RIDTs, the accuracy of rapid molecular assays may be affected by the source of the specimen, specimen handling, and the timing of the collection of the specimen. False negative results may occur due to improper or clinical specimen collection or handling or if the specimen is collected when the patient is no longer shedding detectable flu virus. Although a false positive is rare, it can occur through lab contamination or other factors.[50]

Testing is not needed for all patients with signs and symptoms of flu to make antiviral treatment conditions. A health care practitioner may diagnose an individual with the flu based on symptoms and his or her clinical judgment, irrespective of the test results.[51]

Some pharmacies may currently provide flu testing, as well as other health screenings.[52] However, these pharmacies vary by the types of patients seen, the array of services offered, the type of health care practitioner available, and the type of medications prescribed.

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[48] Center for Disease Control and Prevention, *People at High Risk For Flu Complications*, (last reviewed August 27, 2018), *available at* https://www.cdc.gov/flu/highrisk/index.htm (last visited Feb. 13, 2020).
[49] Center for Disease Control and Prevention, *Rapid Influenza Diagnostic Tests*, (last reviewed October 25, 2016), *available at* https://www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm (last visited Feb. 13, 2020).
[50] Centers for Disease Control and Prevention, *Information on Rapid Molecular Assays, RT-PCR, and other Molecular Assays for Diagnosis of Influenza Virus Infection*, (last reviewed October 21, 2019), *available at* https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm (last visited Feb. 13, 2020).
[51] Id.
[52] See examples: CVS Pharmacy offers services through its MinuteClinic®, which is staffed by nurse practitioners or physician assistants (*see* CVS, *MinuteClinic® Services*, *available at* https://www.cvs.com/minuteclinic/services?WT.ac=MC-Home-Badge1-services (last visited Feb. 13, 2020)

**Reporting of Diseases to the Department of Health**

Any licensed physician, chiropractic physician, nurse, midwife, medical examiners, hospitals, laboratories, or veterinarians licensed in this state must immediately report the diagnosis or suspected diagnosis of a disease of public health importance to the department. The department, by rule, has designated the diseases and conditions that must be reported, as well as the timeframes for such reports. A suspected or confirmed diagnosis of the flu that is caused by a novel or pandemic strain must be reported immediately. However, strep throat is not among the diseases or conditions that must be reported. The practitioner must report the disease or condition on a form developed by the department, which includes information such as the patient's name, demographic information, diagnosis, test procedure used, and treatment given. The practitioner must make the patient's medical records for such diseases available for onsite inspection by the department.[53]

## III. Effect of Proposed Changes:

**Section 1** amends s. 381.0031, F.S., which requires certain health care practitioners, hospitals, and federally-certified laboratories which diagnose or suspect the existence of a disease of public health significance to report that fact to the Department of Health (department). The bill adds the licensed pharmacist with written protocol with a physician that includes ordering and evaluating laboratory and clinical tests to those required to report.

**Section 2** amends the definition of the "practice of the profession of pharmacy" to include the testing for, and treatment of, influenza pursuant to s. 465.1895, F.S., which is created by the bill.

**Section 3** creates s. 465.1895, F.S., which permits a pharmacist to test for and treat influenza if the pharmacist meets all of the following requirements:

- Enters into a written protocol with a supervising physician licensed under chapters 458 or 459, F.S., which meets the requirements for a written protocol pursuant to Board of Medicine (BOM) rules, adopted in consultation with the Board of Osteopathic Medicine (BOOM) and the Board of Pharmacy (BOP), that includes, at a minimum:
  - Terms and conditions required by s. 465.189(7), F.S., which includes;
  - That the pharmacist, or his designee, must follow up with the patient three days after treatment to determine whether the patient's condition has improved; and
  - If the patient's condition has not improved, the pharmacist must do all of the following:
    - Recommend that the patient seek treatment from the patient's primary care physician or, if the patient has no primary care physician, from the pharmacist's supervising physician;
    - Inform the patient's primary care physician that the patient's condition failed to improve three days after treatment or, if the patient has no primary care physician, the pharmacist must so inform the pharmacist's supervising physician; and
    - Document in the patient's records whether the follow-up occurred or whether attempts to contact the patient were unsuccessful.

[53] Section 381.0031, F.S., and Fla. Admin. Code R. 64D-3.029 and 64D-3.030, (2019). See also Florida Department of Health, *Health Care Practitioner Reporting Guidelines for Reportable Diseases and Conditions in Florida*, (October 20, 2016), *available at* http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/_documents/guidelines-health-care.pdf (last visited Feb. 13, 2020).

  - A supervising physician's instructions for the treatment of influenza based on the patient's age, symptoms, and test results, including negative results;
  - A process and schedule for the supervising physician to review the pharmacist's actions under the written protocol;
  - A process and schedule for the pharmacist to notify the supervising physician of the patient's condition, tests administered, test results, and course of treatment; and
  - A procedure to notify the patient's primary care provider within two business days after providing any such testing or treatment, when the patient has a primary care provider.
- Uses instruments and waived tests, as defined in 42 C.F.R. s. 493.2.
- Uses a testing system that:
  - Provides automated readings in order to reduce user subjectivity or interpretation of results;
  - Is capable of directly or indirectly interfacing with electronic medical records systems;
  - Is capable of electronically reporting daily deidentified test results to the appropriate agencies; and
  - Uses an instrument that incorporates both internal and external controls and external calibration that show the reagent and assay procedure is performing properly. External controls must be used in accordance with local, state, and federal regulations and accreditation requirements.
- Is certified through a certification program approved by the BOM, in consultation with the BOOM and the BOP. The program must:
  - Be developed and implemented within 90 days after the effective date of the bill.
  - Required to attend eight hours of BOM-approved continuing education with a curriculum approved by the Accreditation Council for Pharmacy Education; and
  - Provide instructional services, including at a minimum, point-of-care testing for influenza and the safe and effective treatment of influenza.
- Has obtained a full past and present history from the patient on a form promulgated and adopted by rule of the BOM which allows the patient to check off medical conditions from a list and add other conditions that are not listed.
- Prominently displays signage indicating that any patient tested and treated at the pharmacy is advised to seek follow-up care from his or her primary care physician or, if the patient has no primary care physician, from the pharmacist's supervising physician.
- Provides the patient with the name and contact information of the pharmacist's supervising physician and a pamphlet or brochure that meets criteria established by BOM rule informing the patient that:
  - If the test indicates that the patient has influenza, the patient is advised to seek follow-up care from the patient's primary care physician or, if the patient has no primary care physician, from the pharmacist's supervising physician; and
  - If the pharmacist treats the patient for influenza, the pharmacist and the pharmacy where the testing and treating occurred are liable for damages the patient suffers as a result of an adverse reaction to the treatment.
- Treats only with limited medications designed to treat influenza which are approved by the BOM and which the BOM reviews annually.
- Reviews the patient's current prescriptions and recent prescription history to check for relative contraindications involving the intended treatment.
- Maintains at least $250,000 of professional liability insurance.

- Maintains, and makes available, patient records, including the required patient history, test results, and the name and contact information of the pharmacist's supervising physician, for at least five years, using the same standards for confidentiality and record maintenance as required under s. 456.057, F.S.

The bill specifies that a pharmacist may not test for or treat influenza for a patient who:

- Is younger than 18 years of age;
- Is older than 75 years of age;
- Refuses to provide a medical history; or
- Provides a medical history indicating a history of conditions relating to:
  - Heart disease;
  - Bronchial disorders;
  - Pneumonia;
  - Chronic obstructive pulmonary disease;
  - Asthma; or
  - Any other medical conditions the BOM specifies annually by rule.

The bill requires that a supervising physician who enters into a written protocol with a pharmacist must be a primary care physician who is actively practicing in the community in which the pharmacist tests and treats according to BOM rule. A supervising physician may not supervise pharmacists employed at more than four pharmacy locations.

The bill provides that the supervising physician's decision to enter into a written protocol with a pharmacist for the testing and treatment of flu and strep is a professional decision and no person may interfere with that decision regarding entering into such a protocol. A pharmacist may not enter into a written protocol that is to be performed while acting as an employee without the written approval of the owner of the pharmacy.

Implementation of s. 465.1895, F.S., as created by the bill, is contingent on the enactment of an appropriation within the General Appropriations Act which is sufficient to fund the BOM's required duties under the bill.

**Section 4** provides that the bill takes effect upon becoming a law.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The CS/SB 714 would increase the Department of Health's workload associated with the submission and tracking of written protocols between pharmacists and supervising physicians, additional complaints, investigations, and prosecution for non-compliance with the requirements of the bill, updating the Licensing and Enforcement Information Database System to include a new modifier to identify certification, and rulemaking. However, the department anticipates current resources are adequate to absorb the impact of the bill.

The bill includes language that implementation of the Board of Medicine's (BOM) efforts to carry out the duties required by the bill is contingent upon the enactment of an appropriation within the General Appropriations Act.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0031 and 465.003.

This bill creates section 465.1895 of the Florida Statutes.

## IX. Additional Information:

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

**CS by Health Policy on February 18, 2020:**
The CS:

- Removes from the definition of the "practice of professional pharmacy" the testing for and treatment of streptococcus from the underlying bill;
- Changes the underlying bill's rulemaking authority from the BOP to the BOM for rules to:
  - Establish requirements for pharmacist's written protocol with supervising physician to test and treat for influenza;
  - Approve pharmacist's required certification program to test for and treat influenza; and
  - Approve the pharmacist's required one-time, one hour continuing education course required by the certification program.
- Adds the following additional requirements for a pharmacist to test for and treat influenza:
  - Obtain a complete medical history on a BOM approved form;
  - Provide pharmacy signage recommending follow-up for patients tested;
  - Provide the patient with the name and contact information of the supervising physician; and
  - Provide the patient with a BOM approved pamphlet or brochure that includes advising the patient:
- To seek follow-up care if the test is positive; and
  - That the pharmacist and pharmacy are liable for damages from adverse reactions.
  - Treat patients only with medications approved by the BOM, and reviewed annually; and
  - Review the patient's prescription history for contraindications.
- Specifies patients the pharmacist may not test for or treat for influenza.

B. Amendments:

None.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

714
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Chris Nuland

Job Title _____

Address 4427 Herschel St
*Street*

Jacksonville, FL 32210
*City* *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

714
*Bill Number (if applicable)*

Topic Testing for & ~~Treatment~~ Treatment of Infiuenza

*Amendment Barcode (if applicable)*

Name JAKE FARMER

Job Title Director of Government Affairs

Address 227 S Adams St
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone 352 359 6835

Email Jake@frf.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Retail Federation

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 714
*Bill Number (if applicable)*

Topic Test & Treat

*Amendment Barcode (if applicable)*

Name Jeff Scott

Job Title

Address 1430 Piedmont Dr. E.
*Street*

Phone 850 224-6491

Tallahassee FL 32308
*City* *State* *Zip*

Email jscott@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

2/25/20
*Meeting Date*

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

714
*Bill Number (if applicable)*

Topic Test and Treat

*Amendment Barcode (if applicable)*

Name Steve Winn

Job Title Executive Dir.

Address 2544 Blairstone Pines Dr
*Street*
Tallahassee FL 32301
*City* *State* *Zip*

Phone 878-7364

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

Feb 25, 2020
*Meeting Date*

SB 714
*Bill Number (if applicable)*

Topic Testing for Influenza

*Amendment Barcode (if applicable)*

Name DIEGO ECHEVERRI "DEE-YEH-GOH Etch-uh-VEH-REE"

Job Title Legislative Liaison

Address 200 W College Ave
*Street*

Phone

TLH FL
*City* *State* *Zip*

Email decheverri@afphq.org

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

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

Representing Americans For Prosperity

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

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

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

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S-001 (10/14/14)

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

714
*Bill Number (if applicable)*

Topic Testing for and Treatment of Influenza

*Amendment Barcode (if applicable*

Name Brewster Bevis

Job Title Senior Vice President

Address 516 N Adams St
*Street*

Phone 224-7173

Tallahassee FL 32301
*City* *State* *Zip*

Email bbevis@aif.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/1

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

February 25, 2020
*Meeting Date*

CS/SB 714
*Bill Number (if applicable)*

Topic TESTING FOR AND TREATMENT OF INFLUENZA

*Amendment Barcode (if applicable)*

Name Michael Jackson

Job Title Executive Vice President and CEO

Address 610 North Adams Street
*Street*

Tallahassee Florida 32301
*City* *State* *Zip*

Phone (850) 222-2400

Email mjackson@pharmview.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

714
*Bill Number (if applicable)*

Topic Pharmacy / Flu Test & Treat

*Amendment Barcode (if applicable)*

Name Toni Large

Job Title

Address 215 Monroe St
*Street*

Tallahassee, FL 32308
*City* *State* *Zip*

Phone (850) 556-1461

Email toni@largestrategies.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida College of Emergency Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 714
*Bill Number (if applicable)*

Topic Testing for and treatment of Influenza

*Amendment Barcode (if applicable)*

Name Aimee Diaz Lyon

Job Title

Address 119 South Monroe Street, Suite 200
*Street*

Phone 850-205-9000

Tallahassee FL 32301
*City* *State* *Zip*

Email aimee.diazlyon@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Academy of Family Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

2020 a.p. (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/25/~~2019~~ — *Meeting Date*

SB714 — *Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Prescription Drug Coverage

Name David Poole

Job Title Director Legislative Affairs

Address 1825 Country Club Dr — *Street*

Tallahassee — *City* | FL — *State* | 32301 — *Zip*

Phone 850-766-3323

Email david.poole@aidshealth.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing AIDS Healthcare Foundation (AHF)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**By** the Committee on Health Policy; and Senator Hutson

588-03836-20 2020714c1

A bill to be entitled

An act relating to the testing for and treatment of influenza; amending s. 381.0031, F.S.; requiring specified licensed pharmacists to report certain information to the Department of Health; amending s. 465.003, F.S.; revising the definition of the term "practice of the profession of pharmacy"; creating s. 465.1895, F.S.; authorizing pharmacists to test for and treat influenza and providing requirements relating thereto; requiring the written protocol between a pharmacist and a supervising physician to contain certain information, terms, and conditions; requiring the Board of Medicine, in consultation with the Board of Pharmacy and the Board of Osteopathic Medicine, to develop a specified certification program for pharmacists within a specified timeframe; requiring a pharmacist to collect a medical history before testing and treating a patient; requiring a pharmacy in which a pharmacist tests for and treats influenza to display and distribute specified information; providing limitations on the medications a pharmacist may administer to treat influenza; requiring pharmacists to review certain information for a specified purpose before testing and treating patients; requiring a pharmacist who tests for and treats influenza to maintain professional liability insurance in a specified amount; providing recordkeeping requirements for pharmacists who test for and treat influenza; providing that a person may







588-03836-20 2020714c1

not interfere with a physician's professional decision to enter into a written protocol with a pharmacist; providing that a pharmacist may not enter into a written protocol under certain circumstances; requiring the Board of Medicine, in consultation with the Board of Pharmacy and the Board of Osteopathic Medicine, to adopt rules within a specified timeframe; requiring pharmacists to notify a patient's primary care provider and follow up with the treated patient within specified timeframes; prohibiting a pharmacist from testing or treating patients under certain circumstances; specifying circumstances under which a physician may supervise a pharmacist under a written protocol; providing a contingency on implementation; providing an effective date.

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

Section 1. Subsection (2) of section 381.0031, Florida Statutes, is amended to read:

381.0031 Epidemiological research; report of diseases of public health significance to department.—

(2) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; <u>any licensed pharmacist authorized pursuant to a written protocol to order and evaluate laboratory and clinical tests;</u> any hospital licensed under part I of chapter 395; or any laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal

Clinical Laboratory Improvement Amendments, and the federal rules adopted thereunder, which diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

Section 2. Subsection (13) of section 465.003, Florida Statutes, is amended to read:

465.003 Definitions.—As used in this chapter, the term:

(13) "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and conducting other pharmaceutical services. For purposes of this subsection, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. However, nothing in this subsection may be interpreted to permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. "Practice of the profession of pharmacy" also includes any other act, service,





operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The practice of the profession of pharmacy also includes the administration of vaccines to adults pursuant to s. 465.189, the testing for and treatment of influenza pursuant to s. 465.1895, and the preparation of prepackaged drug products in facilities holding Class III institutional pharmacy permits.

Section 3. Section 465.1895, Florida Statutes, is created to read:

465.1895 Testing for and treatment of influenza.—

(1) A pharmacist may test for and treat influenza if all of the following criteria are met:

(a) The pharmacist has entered into a written protocol with a supervising physician licensed under chapter 458 or chapter 459, and such protocol complies with the requirements in subsection (5) and the Board of Medicine's rules.

(b) The pharmacist uses an instrument and a waived test, as that term is defined in 42 C.F.R. s. 493.2.

(c) The pharmacist uses a testing system that:

1. Provides automated readings in order to reduce user subjectivity or interpretation of results.

2. Is capable of directly or indirectly interfacing with electronic medical records systems.

3. Is capable of electronically reporting daily deidentified test results to the appropriate agencies.

4. Uses an instrument that incorporates both internal and external controls and external calibration that show the reagent and assay procedure is performing properly. External controls must be used in accordance with local, state, and federal regulations and accreditation requirements.

(d) The pharmacist is certified to test for and treat influenza pursuant to a certification program approved by the Board of Medicine, in consultation with the board and the Board of Osteopathic Medicine. The certification program must be developed and implemented within 90 days after the date upon which this section becomes effective and must require that the pharmacist attend, on a one-time basis, 8 hours of continuing education courses approved by the Board of Medicine. The continuing education curriculum must be provided by an organization that is approved by the Accreditation Council for Pharmacy Education to provide instructional services and must include, at a minimum, point-of-care testing for influenza and the safe and effective treatment of influenza.

(e) The pharmacist collects from the patient a full history of the patient's past and present medical conditions on a form adopted by the Board of Medicine by rule which allows the patient to check off medical conditions from a list and add other conditions that are not listed. The history must be maintained as part of the patient's records in accordance with subsection (3).

(f) The pharmacy in which a pharmacist tests for and treats influenza prominently displays signage indicating that any patient tested and treated at the pharmacy is advised to seek followup care from his or her primary care physician or, if the







patient has no primary care physician, from the pharmacist's supervising physician.

(g) The pharmacist who tests for or treats influenza provides the patient with the name and contact information for the pharmacist's supervising physician and a pamphlet or brochure that meets criteria established by the Board of Medicine by rule informing the patient that:

1. If the test indicates that the patient has influenza, the patient is advised to seek followup care from the patient's primary care physician or, if the patient has no primary care physician, from the pharmacist's supervising physician; and

2. If the pharmacist treats the patient for influenza, the pharmacist and the pharmacy where the testing and treating occurred are liable for damages the patient suffers as a result of an adverse reaction to the treatment.

(h) The pharmacist's treatment is limited to medications designed to treat influenza which are approved by the Board of Medicine and which the Board of Medicine shall review annually.

(i) The pharmacist, prior to treating the patient, reviews the patient's current prescriptions and recent prescription history to check for relative contraindications involving the pharmacist's intended treatment.

(2) A pharmacist may not enter into a written protocol under this section unless he or she maintains at least $250,000 of professional liability insurance and is certified as required in paragraph (1)(d).

(3) A pharmacist who tests for and treats influenza shall maintain and make available patient records using the same standards for confidentiality and maintenance of such records as

those that are imposed on health care practitioners under s. 456.057. Each patient's records maintained under this subsection must include confirmation that the requirements of paragraphs (1)(e) and (1)(g) were fulfilled. Such records shall be maintained for at least 5 years.

(4) The decision by a supervising physician licensed under chapter 458 or chapter 459 to enter into a written protocol under this section is a professional decision on the part of the physician and a person may not interfere with a physician's decision regarding entering into such a protocol. A pharmacist may not enter into a written protocol that is to be performed while acting as an employee without the written approval of the owner of the pharmacy.

(5) The Board of Medicine, in consultation with the board and the Board of Osteopathic Medicine, shall adopt rules establishing requirements for the written protocol within 90 days after the date upon which this section becomes effective. At a minimum, the written protocol shall include:

(a) The terms and conditions required in s. 465.189(7).

(b) Specific categories of patients for whom the supervising physician authorizes the pharmacist to test for and treat influenza.

(c) The supervising physician's instructions for the treatment of influenza based on the patient's age, symptoms, and test results, including negative results.

(d) A process and schedule for the supervising physician to review the pharmacist's actions under the written protocol.

(e) A process and schedule for the pharmacist to notify the supervising physician of the patient's condition, tests







administered, test results, and course of treatment.

(6) When the patient has a primary care provider, a pharmacist who provides testing for or treatment of influenza under this section shall notify the patient's primary care provider within 2 business days after providing any such testing or treatment.

(7) If a pharmacist tests for and treats influenza for a patient under this section, the pharmacist or his or her designee must follow up with the patient 3 days later to determine whether the patient's condition has improved, and if the patient informs the pharmacist that his or her condition has not improved, the pharmacist shall do all of the following:

(a) Recommend that the patient seek treatment from the patient's primary care physician or, if the patient has no primary care physician, from the pharmacist's supervising physician.

(b) Inform the patient's primary care physician that the patient's condition failed to improve 3 days after treatment or, if the patient has no primary care physician, the pharmacist shall so inform the pharmacist's supervising physician.

(c) Document in the patient's record maintained under subsection (3) whether the followup required under this subsection occurred or whether attempts to contact the patient were unsuccessful.

(8) A pharmacist may not test for or treat influenza under this section for a patient who:

(a) Is younger than 18 years of age;

(b) Is older than 75 years of age;

(c) Refuses to provide a medical history under paragraph

(1)(e); or

(d) Provides a medical history under paragraph (1)(e) indicating a history of conditions relating to heart disease, bronchial disorders, pneumonia, chronic obstructive pulmonary disease, asthma, or any other medical conditions as determined by the Board of Medicine by rule on an annual basis.

(9) A supervising physician who enters into a written protocol with a pharmacist under this section must be a primary care physician who is actively practicing in the community in which the pharmacist tests and treats under this section according to Board of Medicine rule. A supervising physician may not enter into such a protocol with pharmacists employed at more than four pharmacy locations.

(10) Implementation of this section is contingent upon the enactment of an appropriation within the General Appropriations Act which is sufficient to fund the Board of Medicine's efforts to carry out its duties as required under this section.

Section 4. This act shall take effect upon becoming a law.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | SB 926 |
| INTRODUCER: | Senator Harrell |
| SUBJECT: | Health Care Practitioner Licensure |
| DATE: | February 24, 2020 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Kibbey | Brown | HP | **Favorable** |
| 2. | Howard | Kidd | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

## I. Summary:

SB 926 authorizes Florida to participate in the Interstate Medical Licensure Compact (IMLC or Compact) for the licensure of physicians and osteopathic physicians. The bill allows a physician who is licensed through the Compact and whose licensed is suspended or revoked through the Compact as a result of disciplinary action taken against the physician's license in another state, to have a formal hearing before the Florida Division of Administrative Hearings.

The bill also amends health care practitioner licensure, certification, and registration provisions in chapter 456 to remove prohibitions and penalties for applicants and practitioners who have failed to repay their student loans or who are listed on the listed on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

The bill will have a significant impact on the Department of Health (DOH) that would require three (3) additional full-time equivalent (FTE) positions and $152,280 in additional budget authority to support the workload associated with participating in the Compact.

The bill takes effect on July 1, 2021.

## II. Present Situation:

### *Occupational Licensure Compacts*

Interstate compacts are authorized under the U.S. Constitution, Article I, Section 10, cl. 3.[1] Compacts that affect a power delegated to the federal government or that affect or alter the

[1] "No state shall, without the Consent of Congress…enter into any Agreement or Compact with another State, or with a foreign Power[.]" *see* U.S. CONST. art. I, s. 10, cl. 3. While the language of the provision says congressional approval is required, not all compacts require congressional approval.

political balance within the federal system require the consent of Congress.[2] There are currently more than 200 compacts between the states, including 50 national compacts, of which six are for health professions.[3, 4]

The licensing of professions is predominantly a state responsibility as each state has developed its own regulations, oversight boards, and requirements for dozens of professions and occupations. More than 25 percent of individuals within the American workforce are currently in a profession that requires a professional license.[5]

In September 2018, the Federal Trade Commission (FTC) looked at the issue of state-by-state occupational licensure and its unintended consequences. In particular, the FTC noted that state-by-state licensing can have a particularly hard effect on those in the military and their spouses who are required to move frequently, those who provide services across state lines, or deliver services through telehealth.[6] The FTC also suggested that improved licensed portability would enhance competition, choice, and access for consumers, especially where services may be in short supply.[7]

***Interstate Medical Licensure Compact***

The Interstate Medical Licensure Compact provides an expedited pathway for medical and osteopathic physicians to qualify to practice medicine across state lines within a Licensure Compact. Currently, 29 states, the District of Columbia and the Territory of Guam which cover 43 medical and osteopathic boards participate in the Compact.[8]

The Interstate Medical Licensure Compact Commission (Commission) is created in Section 11 of the Compact and serves as the administrative arm of the Compact and member states. Each member state of the Compact has two voting representatives on the Commission. If a state has

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[2] This issue was settled in *Virginia v. Tennessee*, 148 U.S. 503 (1893). *See also Interstate Compacts & Agencies (1998),* William Kevin Voit, Sr. Editor and Gary Nitting, Council of State Governments, pg. 7, *available at* http://www.csg.org/knowledgecenter/docs/ncic/CompactsAgencies98.pdf (last visited Jan. 22, 2020)

[3] Ann O'M. Bowman and Neal D. Woods, *Why States Join Interstate Compacts,* The Council of State Governments (March 2017) p. 19 and 20, http://knowledgecenter.csg.org/kc/system/files/Bowman%202017.pdf, (last visited Jan. 22, 2020).

[4] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. 9, *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Jan. 22, 2020). The six health professions are nurses, medical, emergency medical services, physical therapy, psychology, and advanced registered nurse practitioners. The only two compacts currently operational are the Enhanced Nurse Compact and the physicians compacts as the others are awaiting the completion of an administrative structure.

[5] Albert Downs and Iris Hentze, *License Overload? Lawmakers are questioning whether we've gone too far with occupational and professional licensing* (April 1, 2018), STATE LEGISLATURES MAGAZINE, *ncsl.org,* http://www.ncsl.org/bookstore/state-legislatures-magazine/occupational-licensing-can-balance-safety-and-employment-opportunities.aspx (last visited Jan. 22, 2020).

[6] Federal Trade Commission, *Policy Perspectives, Options to Enhance Occupational License Portability* (September 2018), *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Jan. 22, 2020).

[7] *Id*.

[8] Interstate Medical Licensure Compact, *The IMLC,* https://imlcc.org/ (last visited Jan. 22, 2020).

separate regulatory boards for allopathic and osteopathic, then the representation is split between the two boards.[9]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the Compact.[10] The providers' applications are expedited by using the information previously submitted in their State of Principal Licensure (SPL). The physician can then select in which states to practice in after a fresh background check is completed.

To qualify for consideration, the physician must:

- Hold a full, unrestricted medical license from a Compact member state and meet one of the following additional qualifications:
  - The physician's primary residence is in the SPL; or
  - The physician's practice of medicine occurs in the SPL for at least 25 percent of the time; or
  - The physician's employer is located in the SPL; or
  - The physician uses the SPL as his or her state of residence for U.S. federal income tax purposes.

Additionally, the physician must maintain his or her licensure from the SPL at all times. A physician may change his or her SPL after the original qualification. Other requirements for eligibility for a Compact license include:

- Graduation from an accredited medical school, or a school listed in the International Medical Education Directory;
- Successful completion of graduate medical education from a school which has received accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA);
- Passage – in no more than three attempts – of each component of the U.S. Medical Licensing Exam (USMLE) or the Comprehensive Osteopathic Medical Licensing Exam (COMLEX-USA) or equivalent;
- Hold a current specialty certification or time-unlimited certification by an American Board of Medical Specialties (ABMS) or American Osteopathic Association/Bureau of Osteopathic Specialists (AOABOS) board;
- Not having any history of disciplinary actions as to their medical license.
- Not having a criminal history;
- Not having any history of controlled substance actions as to their medical license; and
- Not currently under investigation.[11]

The Commission charges an application fee of $700, which an applicant pays directly to the Commission. Each state's fee for licensure is separate from the Commission's application fee. The individual state fees currently vary from a low of $75 in Alabama and Wisconsin to a high of $790 in Maryland.[12]

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[9] Interstate Medical Licensure Compact, Section 11, (d), p. 11, https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Jan. 22, 2020).
[10] Interstate Medical Licensure Compact, *The IMLC*, https://imlcc.org/ (last visited Jan. 22, 2020).
[11] Interstate Medical Licensure Compact, *Do I Qualify*, https://imlcc.org/do-i-qualify/ (last visited Jan. 22, 2020).
[12] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Jan. 22, 2020).

***Regulation of Physicians in Florida***

Licensing of Florida Physicians

The regulation of the practices of medicine and osteopathic medicine in Florida fall under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians.

The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[13] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[14]

The current licensure application fee for a medical doctor is $350 and is non-refundable.[15] Applications must be completed within one year. If a license is approved, the initial license fee is $355.[16] The entire process typically takes from two to six months from the time the application is received.[17]

For osteopathic physicians, the current application fee is non-refundable at $200, and if approved, the initial licensure fee is $305.[18] The same application validity provision of one year applies and the processing time of two to six months is the range of time that applicants should anticipate for a decision.[19] If an applicant is licensed in another state, the applicant may request that Florida "endorse" those exam scores and demonstrate that the license was issued based on those exam scores. The applicant must also show that the exam was substantially similar to any exam that Florida allows for licensure.[20]

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. However, the practice acts are not identical in their licensure offerings as shown in the table below, which compares some of the contents of the two practice acts. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:

- Complete an application form as designated by the appropriate regulatory board;

[13] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[14] *Id.*
[15] Florida Board of Medicine, *Medical Doctor - Fees*, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted (last visited Jan. 22, 2020).
[16] *Id.*
[17] Florida Board of Medicine, *Medical Doctor Unrestricted - Process*, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Jan. 22, 2020).
[18] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees*, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited Jan. 22, 2020).
[19] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process*, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited Jan. 22, 2020).
[20] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Requirements*, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited Jan. 22, 2020).

- Be at least 21 years of age;
- Be of good moral character;
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education;
- Have not previously committed any act that would constitute a violation of chapter 458 or chapter 459, as applicable, or lead to regulatory discipline;
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority;
- Must submit a set of fingerprints to the Department of Health (DOH) for a criminal background check;
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association;
- Demonstrate that she or he has successfully completed a resident internship (osteopathic medicine) or supervised clinical training (medical) of not less than 12 months in a hospital approved for this purpose by the applicant's respective professional association; and
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners, no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.[21]

| **Statutory References for Practice Acts - Licensure<br>Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.** | | |
|---|---|---|
| **Issue** | **Medical Physicians** | **Osteopathic Physicians** |
| Regulatory Board | Board of Medicine<br>s. 458.307, F.S. | Board of Osteopathic Medicine<br>s. 459.004, F.S. |
| Rulemaking Authority | s. 458.309., F.S. | s. 459.005, F.S. |
| General Requirements for Licensure | s. 458.311, F.S. | s. 459.0055, F.S. |
| Licensure Types | | |
| *Restricted License* | s. 458.310, F.S. | No provision |
| *Restricted License Certain foreign physicians* | s. 458.3115, F.S. | No provision |
| *Licensure by Endorsement* | s. 458.313, F.S. | No provision |
| *Temporary Certificate (Approved Cancer Centers)* | s. 458.3135, F.S. | No provision |
| *Temporary Certificate (Training Programs)* | s. 458.3137, F.S. | No provision |
| *Medical Faculty Certificate* | s. 458.3145, F.S. | s. 459.0077, F.S. |
| *Temporary Certificate Areas of Critical Need* | s. 458.315, F.S. | s. 459.0076, F.S. |

[21] *See* ss. 458.311, F.S. and 459.0055, F.S.

| Statutory References for Practice Acts - Licensure<br>Medical and Osteopathic Physicians: Ch. 458 and 459, F.S. | | |
|---|---|---|
| **Issue** | **Medical Physicians** | **Osteopathic Physicians** |
| *Temporary Certificate Areas of Critical Need – Active Duty Military & Veterans* | s. 458.3151, F.S. | s. 459.00761, F.S. |
| *Public Health Certificate* | s. 458.316, F.S. | No provision |
| *Public Psychiatry Certificate* | s. 458.3165, F.S. | No provision |
| *Limited Licenses* | s. 458.317, F.S. | s. 459.0075, F.S. |
| *Expert Witness* | s. 458.3175, F.S. | s. 459.0066, F.S. |
| License Renewal | s. 458.319, F.S.<br>$500/max/biennial renewal | s. 459.008, F.S. |
| Financial Responsibility *Condition of Licensure* | s. 458.320, F.S. | s. 459.0085, F.S. |
| Penalty for Violations | s. 458.327, F.S. | s. 459.013, F.S. |

In Florida, to practice medicine an individual must become a licensed medical doctor through licensure by examination[22] or licensure by endorsement.[23] Florida does not recognize another state's medical license or provide licensure reciprocity.[24] Licensure by endorsement requires the medical physician to meet the following requirements:

- Be a graduate of an allopathic U.S. medical school recognized and approved by the U.S. Office of Education and completed at least one year of approved residency training; or
- Be a graduate of an allopathic international medical school and have a valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate and completed an approved residency of at least two years in one specialty area; or
- Be a graduate who has completed the formal requirements of an international medical school except the internship or social service requirement, passed parts I and II of the National Board of Medical Examiners (NBME) or ECFMG equivalent examination, and completed an academic year of supervised clinical training (5th pathway) and completed an approved residency of at least two years in one specialty area.
- And both of the following:
    - Passed all parts of a national examination (the NBME; the Federation Licensing Examination offered by the Federation of State Medical Boards of the United States, Inc.; or the United States Medical Licensing Exam); and
    - Be licensed in another jurisdiction and actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years; or passed a board-approved clinical competency examination within the year preceding filing of the application or;

[22] Section 458.311, F.S.
[23] Section 458.313, F.S.
[24] Notwithstanding this lack of reciprocity, physicians and other health care practitioners licensed out-of-state who meet certain requirements may register with the DOH under s. 456.47(4), F.S., and provide services to patients within Florida via telehealth, which is defined as "the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration." The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

successfully completed a board approved postgraduate training program within two years preceding filing of the application.[25]

Financial Responsibility

Florida-licensed allopathic physicians are required to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.[26] Physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim.[27] Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim.[28] Certain physicians who are exempted from the requirement to carry professional liability insurance or other financial responsibility must provide notice to their patients.[29]

Florida-licensed osteopathic physicians have similar financial responsibility requirements as allopathic physicians[30]. With specified exceptions, the DOH must suspend, on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.[31]

Disciplinary Process: Fines and Sanctions

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in the DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 458.331, F.S., identifies acts that constitute grounds for which disciplinary actions may be taken against a medical physician and s. 459.015, F.S., identifies acts specific to an osteopathic physician. Some parts of the review process are public and some are confidential.[32]

Complaints and allegations are received by the MQA unit for determination of legal sufficiency and investigation. A determination of legal sufficiency is made if the ultimate facts show that a violation has occurred.[33] The complainant is notified by letter as to the whether the complaint will be investigated and if any additional information is needed. Complaints which involve an immediate threat to public safety are given the highest priority.

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[25] Florida Board of Medicine, *Medical Doctor-Unrestricted; Licensure by Endorsement,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Jan. 22, 2020).
[26] Section 458.320, F.S.
[27] Section 458.320(2), F.S.
[28] Section 458.320(1), F.S.
[29] Section 458.320(5)(f) and (g), F.S.
[30] Section 459.0085, F.S.
[31] Sections 458.320(8) and 459.0085(9), F.S.
[32] Fla. Department of Health, Division of Medical Quality Assurance, *Enforcement Process*, (last updated Nov. 2019) http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/enforcement-process-chart.pdf). (last visited Jan. 23, 2020).
[33] Fla. Department of Health, *Consumer Services – Administrative Complaint Process,* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited Jan. 23, 2020).

The DOH is responsible for reviewing each report to determine if discipline against the provider is warranted.[34] Authorization for the discipline of allopathic and osteopathic physicians can be found in state law and administrative rule.[35] If held liable for one of the offenses, the fines and sanctions by category and by offense are based on whether it is the physician's first, second, or third offense.[36] The boards may issue a written notice of noncompliance for the first occurrence of a single minor violation.[37] The amount of fines assessed can vary depending on the severity of the situation, such as improper use of a substance to concealment of a material fact. A penalty may come in the form of a reprimand, a licensure suspension, or revocation followed by some designated period of probation if there is an opportunity for licensure reinstatement. Other sanctions may include supplemental continuing education requirements and require proof of completion before the license can be reinstated.

***Health Care Practitioners – Defaults on Student Loans***

Section 456.072(1)(k), F.S., requires the suspension of a health care practitioner's license when the licensee is in default on a student loan that is guaranteed by the state or federal government. The suspension remains in effect until the licensee enters into a new payment agreement. That agreement is followed by a mandatory probation for the duration of the student loan and a fine in the amount of 10 percent of the defaulted loan amount. These fines are deposited into the Medical Quality Assurance Trust Fund.

Section 456.0721, F.S., requires the DOH to obtain information from the federal government on health care practitioners who are in default on guaranteed student loans. The DOH must annually report to the Legislature data on licensees in default.

Section 456.074 (4), F.S., requires the DOH to issue an emergency order suspending the license of any licensee who, after notice from the DOH, fails to provide proof within 45 days that new payment terms have been agreed to by parties to the loan.

In State Fiscal Year 2017-2018, the DOH reported 850 student loan defaults.[38] During this same time, 76 investigations were completed, and 26 emergency suspension orders were filed.[39] In State Fiscal Year 2018-2019, the DOH reported 87 student loan defaults.[40] During this same time, 250 investigations were completed, and 121 emergency suspension orders were filed.[41]

***The Office of Inspector General's List of Excluded Individuals and Entities***

Paragraphs 456.0635(2)(e) and (3)(e), F.S. require the DOH to refuse to issue or renew a license, registration, or certification to a candidate or applicant if the candidate or licensee is currently

[34] *See* ss. 458.351(5) and 459.026(5), F.S.
[35] *See s*s. 458.307 and 459.004, F.S., for the regulatory boards, and ss. 64B8-8 and 64B15-19, F.A.C., for administrative rules relating to disciplinary procedures.
[36] *Id.*
[37] Sections 64B8-8.011 and 64B15-19.0065, F.A.C. A minor violation is deemed to not endanger the public health, safety, and welfare and does not demonstrate a serious inability to practice.
[38] Department of Health, *House Bill 77 Agency Analysis* (on file with the Senate Committee on Health Policy).
[39] *Id.*
[40] *Id.*
[41] *Id.*

listed on the U.S. Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities (LEIE).

The Office of Inspector General (OIG) has the authority to exclude individuals and entities from federally funded health care programs under the authority of sections 1128 and 1156 of the Social Security Act. Exclusions are imposed for a number of reasons:[42]

- Mandatory exclusions: OIG is required by law to exclude from participation in all federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.
- Permissive exclusions: OIG has discretion to exclude individuals and entities on a number of grounds, including (but not limited to) misdemeanor convictions related to health care fraud other than Medicare or a state health program, fraud in a program (other than a health care program) funded by any federal, state or local government agency; misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a federal health care program; engaging in unlawful kickback arrangements; defaulting on health education loan or scholarship obligations; and controlling a sanctioned entity as an owner, officer, or managing employee. [emphasis added]

Section 1128(b)(14) of the Social Security Act and 42 U.S.C. s. 1320a-7(b)(14), provide that a default on a health education loan or scholarship obligation is permissive grounds for being placed on the LEIE and that such exclusion shall last until the default or obligation is resolved. If a candidate or applicant is placed on the LEIE for a default on such a loan, the DOH would be obligated to deny that person's application for initial license or renewal of an existing license.

***Sovereign Immunity***

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [43]

In 1973, the Legislature enacted s. 768.28, F.S., a partial waiver of sovereign immunity, allowing individuals to sue state government and its subdivisions.[44] According to subsection (1), individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . ." Section 768.28(5),

[42]Office of Inspector General, *Background Information*, https://oig.hhs.gov/exclusions/background.asp (last visited Jan. 23, 2020).
[43] FLA. CONST. art. X, s. 13.
[44] Chapter 73-313, L.O.F., codified at s. 768.28, F.S.

F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

***OPPAGA Report 19-07*[45]**

Chapter 2019-138, Laws of Florida, directed the Office of Program Policy Analysis and Government Accountability (OPPAGA) to analyze the Interstate Medical Licensure Compact (which is reflected in SB 926 as section 7) and develop recommendations addressing Florida's prospective entrance into the Compact. On October 1, 2019, OPPAGA published Report No. 19-07. To avoid legal conflicts, the OPPAGA recommended in the report that the Legislature:

- Repeal Florida's initial licensure provisions that fall outside of the Compact's licensure provisions. Florida does not license persons who are listed on the LEIE. The Compact has no comparable requirement. (Addressed in sections 3-6 of SB 926.)
- Enact statutory language providing physicians who practice in Florida whose licenses were revoked in their State of Principal License (SPL) an opportunity to challenge the reason for the revocation or suspension in Florida. (Addressed in section 8 of SB 926.)
- Enact statutory language clarifying that the Compact pays claims or judgments arising from the Commission's employment-related actions in the state. (Addressed in section 10 of SB 926.)
- Provide an exception from public meeting requirements to allow closed meetings of the Commission. (Addressed in linked SB 928.)
- Provide an exception from public records requirements to exempt application records received by the Commission from disclosure. (Addressed in linked SB 928.)
- Set a Compact implementation date to ensure that the DOH would have adequate time to make required changes to rule, forms, and technological infrastructure in order to process licenses through the Compact. (SB 926 has an effective date of July 1, 2021.)

## III. Effect of Proposed Changes:

**Section 1** creates section 458.3129, F.S., to provide that an allopathic physician licensed to practice medicine through the Interstate Medical Licensure Compact (Compact) is deemed to be licensed under chapter 458, F.S.

**Section 2** creates section 459.074, F.S., to provide that an osteopathic physician licensed to practice medicine through the Compact is deemed to be licensed under chapter 459, F.S. (The bill's first two sections are needed to authorize physicians licensed through the Compact to practice in Florida under the Florida Statutes.)

**Federal List of Excluded Individuals and Entities / Student Loans**

**Section 3** amends section 456.0635, F.S., to remove the requirement that each board within the jurisdiction of the Department of Health (DOH), or the DOH itself if there is no board, prohibit a candidate from being examined for or issued, or having renewed a license, certificate, or registration to practice a health care profession if he or she is listed on the U.S. Department of

[45] Office of Program Policy Analysis and Gov't Accountability, Florida Legislature, *Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts*, Report No. 19-07, (Oct. 1, 2019) *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1907rpt.pdf (last visited Jan. 23, 2020).

Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities. Many of the mandatory and permissive exclusions included on the List of Excluded Individuals and Entities are banned from the initial licensure, certification, or registration or renewal of licensure, certification, or registration in other provisions of the Florida Statutes.[46]

**Section 4** amends section 456.072, F.S. to remove a provision classifying the failure to repay a student loan issued or guaranteed by the state or federal government in accordance with the terms of the loan as a failure to perform a statutory or legal obligation and removes penalties.

**Section 5** repeals section 456.0721, F.S. to remove provisions requiring the DOH to obtain information from the federal government on health care practitioners who are in default on guaranteed student loans. This also removes a provision requiring the DOH to annually report to the Legislature data on licensees in default.

**Section 6** amends section 456.074, F.S. to remove the requirement, and related provisions, that the DOH immediately suspend the licenses of certain health care practitioners for failing to provide proof of new payment terms for defaulted student loans within a specified timeframe.

**Interstate Medical Licensure Compact**

**Section 7** creates the Compact as s. 456.4501, F.S., which enters Florida into the Compact. The Compact has 24 sections that establish the Compact's administration and components and prescribe how the Commission will oversee the Compact and conduct its business. The table below describes new statutory language, by Compact section, which creates the components of the Compact.

| **Provisions of the Interstate Medical Licensure Compact** | | |
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| **Section** | **Title** | **Description** |
| 1 | Provides the purpose of the Compact<br><br>Establishes prevailing standard of care | The purpose of the Interstate Medical Licensure Compact (compact) is to provide a streamlined, comprehensive process that allows physicians to become licensed in multiple states. It allows physicians to become licensed without changing a state's Medical Practice Act(s).<br><br>The Compact also adopts the prevailing standard of care based on where the patient is located at the time of the patient-provider encounter. Jurisdiction for disciplinary action or any other adverse actions against a physician's license is retained in the jurisdiction where the license is issued to the physician. |
| 2 | Definitions<br><br>Establishes standard definitions for | Definitions are provided for:<br>- Bylaws: means those Bylaws established by the Commission pursuant to Section 11 for its governance, direction, and control of its actions and conduct.<br>- Commissioner: means the voting representative appointed by each member board pursuant to Section 11 whereby each member state |

[46] *See* s. 456.0635, F.S. *See also* Office of Inspector General, *Exclusion Authorities,* https://oig.hhs.gov/exclusions/authorities.asp (last visited Jan. 23, 2020).

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | operation of the Compact and the Commission. | appoints two members to the Commission. If the member state has two medical boards, the two representatives should be split between the two boards.<br>- Conviction: means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. A conviction also means evidence of an entry of a conviction of a criminal offense by the court shall be considered final for the purposes of disciplinary action by a member board.<br>- Expedited license: means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the Compact.<br>- Interstate Commission: means the interstate commission created pursuant to Section 11.<br>- License: means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.<br>- Medical Practice Act: means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state. (In Florida, the Medical Practice Act for allopathic medicine is under ch. 458, F.S., and for osteopathic medicine, under ch. 459, F.S.)<br>- Member Board: means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. (The Florida Board of Medicine and the Florida Board of Osteopathic Medicine are responsible for the licensure, regulation, and education of physicians in Florida.)<br>- Member State: means a state that has enacted the Compact.<br>- Practice of medicine: means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical, or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.<br>- Physician means: any person who is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent; passed each component of the USMLE or the Comprehensive Osteopathic Medical Licensing Examination (COMPLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes; successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the |

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | | expedited Compact process; possesses a full and unrestricted license to engage in the practice of medicine issued by a member board; has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction; has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.<br>- Offense means: A felony, high court misdemeanor, or crime of moral turpitude.<br>- Rule means: A written statement by the Commission promulgated pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission, and has the force and effect of statutory law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule.<br>- State means: Any state, commonwealth, district, or territory of the United States.<br>- State of Principal License means: A member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact. |
| 3 | Eligibility<br><br>Provides minimum requirements to receive an expedited license | To be eligible to participate and receive an expedited license, a physician must meet the requirements of Section 2 (definition of physician).<br><br>A physician who does not meet the requirements of Section 2 may obtain a license to practice medicine in a member state outside of the Compact if the individual complies with all of the laws and requirements to practice medicine in that state. |
| 4 | State of Principal License (SPL)<br><br>Defines a SPL | The Compact requires participating physicians to designate a State of Principal License (SPL) for purposes of registration for expedited licensure if the physician possesses a full and unrestricted license to practice medicine in that state. The SPL must be a state where:<br>- The physician has his/her primary residence, or<br>- The physician has at least 25 percent of his/her practice, or<br>- The state where the physician's employer is located.<br>If no state qualifies for one of the above options, then the state of residence as designated on physician's federal income taxes. A SPL may be re-designated at any time as long as the physician possesses a full and unrestricted license to practice medicine in that state. The |

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | | Commission is authorized to develop rules to facilitate the re-designation process. |
| 5 | Application and Issuance of Expedited Licensure<br><br>*Qualifications*<br><br>*Commission rulemaking provisions* | Section 5 of the Compact establishes the process for the issuance of the expedited license.<br><br>A physician must file an application with the member board of the state selected as the SPL. The SPL will evaluate the application to determine whether the physician is eligible for the expedited licensure process and issue a letter of qualification, either verifying or denying eligibility, to the Commission.<br>- Static Qualifications: Include verification of medical education, graduate medical education, results of any medical or licensing examinations and any other qualifications set by the Commission through rule.<br>- Performance of Criminal Background Checks by the member board through FBI, with the exception of federal employees who have suitability determined in accordance with U.S. 5 C.F.R. section 731.202.<br>- Appeals on eligibility determinations are handled through the member state.<br>- Upon completion of eligibility verification process with member state, applicants suitable for an expedited license are directed to complete the registration process with the Commission, including the payment of any fees.<br>- After receipt of registration and payment of fees, the physician receives his/her expedited license. The license authorizes the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state.<br>- An expedited license shall be valid for a period consistent with the member state licensure period and in the same manner as required for other physicians holding a full and unrestricted license.<br>- An expedited license obtained through the Compact shall be terminated if a physician fails to maintain a license in the SPL for a non-disciplinary reason, without redesignation of a new SPL.<br>- The Commission is authorized to develop rules relating to the application process, including fees and issuing the expedited license. |
| 6 | Fees for Expedited Licensure<br><br>*Rulemaking authority* | A member state is authorized to charge a fee for an expedited license that is issued or renewed through the Compact. (In Florida, the DOH is already authorized under current law to charge fees for physician licensure.)<br><br>The Commission is authorized is develop rules relating to fees for expedited licenses. The rules are not permitted to limit the authority of the member states, the regulating authority of the member states, or to impose and determine the amount of the fee charged by the member states. |

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| 7 | Renewal and Continued Participation<br><br>*Renewal license process created*<br><br><br><br><br><br>*Continuing education required for renewal with member state*<br><br>*Fees collected, if any, by member state.*<br><br>*Rulemaking authority.* | A physician with an expedited license in a member state must complete a renewal process with the Commission if the physician:<br>- Maintains a full and unrestricted license in a SPL.<br>- Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction.<br>- Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action relating to non-payment of fees related to a license.<br>- Has not had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement Administration.<br>Physicians are required to comply with all continuing education and professional development requirements for renewal of a license issued by a member state.<br><br>The Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician's license shall be renewed. Any information collected during the renewal process shall also be shared with all member boards.<br><br>The Commission is authorized to develop rules to address the renewal of licenses. |
| 8 | Coordinated Information Systems<br><br>*Authorized to create database of all applicants*<br><br>*By request, may share data*<br><br>*Rulemaking authority* | The Commission is required to establish a database of all licensed physicians who have applied for licensure. Member boards are required to report disciplinary or investigatory actions as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission.<br><br>Upon request, member boards shall share complaint or disciplinary information about physicians to another member board. All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.<br><br>The Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards. |
| 9 | Joint Investigations<br><br>*Permits joint investigations between the* | Licensure and disciplinary records of physicians are deemed investigative.<br><br>A member board may participate with other member boards in joint investigations of physicians licensed by the member boards in |

| Provisions of the Interstate Medical Licensure Compact | | |
|---|---|---|
| **Section** | **Title** | **Description** |
| | *state and the member boards* | addition to the authority granted by the member board and its respective Medical Practice Act or other respective state law.<br><br>Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact. Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine. |
| 10 | Disciplinary Actions<br><br>*Discipline by a member state has reciprocal actions*<br><br>*Licensure actions specific actions to reinstate* | Any disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state.<br><br>If the physician's license is revoked, surrendered, or relinquished in lieu of discipline in the SPL, or suspended, then all licenses issued to that physician by member boards shall be automatically placed, without any further action necessary by any member board, on the same status. If the SPL subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective member board takes action to specifically reinstate the license in a manner consistent with the Medical Practice Act in that state.<br><br>If a disciplinary action is taken against the physician in a member state that is the physician's SPL, any other member board may deem the action conclusive as to matter of law and fact decided, and:<br>- Impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or<br>- Pursue separate disciplinary action against the physician under the Medical Practice Act, regardless of the action taken in other member states.<br>If a license granted to a physician by a member board is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board or boards shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the 90-day suspension period in a manner consistent with the Medical Practice Act of that state. |

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| 11 | Interstate Medical Licensure Compact Commission<br><br>*Recognizes creation of Commission and state's representative with 2 Commissioners, one from each regulatory board*<br><br>*Availability of Commission meetings, except for certain topics*<br><br>*Availability of public data from the Commission*<br><br>*Public notice required*<br><br>*Creates an executive committee to act on behalf of the Commission* | The member states create the Interstate Medical Licensure Compact Commission as a joint agency of the member states and administration of the Compact. The Commission has all the duties, powers, and responsibilities set forth in the Compact, plus any other powers conferred upon it by the member states through the Compact.<br><br>Each member state has two (2) two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory boards, the member state shall appoint one representative from each member board.<br><br>A Commissioner shall be:<br>- An allopathic or osteopathic physician appointed to a member board;<br>- Executive director, executive secretary, or similar executive of a member board; or<br>- Member of the public appointed to a member board.<br>The Commission shall meet at least once per calendar year and a portion of the meeting shall be a business meeting that includes the election of officers. The Chair may call additional meetings and shall call for all meeting upon the request of a majority of the member states.<br><br>Meetings are permitted via telecommunication according to the Bylaws.<br><br>Each Commissioner is entitled to one vote. A majority of Commissioners shall constitute a quorum, unless a larger quorum is required by the Bylaws of the Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who meets the requirements of being a Commissioner.<br><br>The Commission shall provide public notice of all meetings and all meetings shall be open to the public. A meeting may be closed to the public, in full or in portion, when it determines by a two-thirds (2/3) vote of the Commissioners present, that an issue or matter would be likely to:<br>- Relate solely to the internal personnel practices and procedures of the Interstate Commission;<br>- Discuss matters specifically exempted from disclosure by federal statute;<br>- Discuss trade secrets, commercial, or financial information that is privileged or confidential; |

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | | - Involve accusing a person of a crime, or formally censuring a person;<br>- Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;<br>- Discuss investigative records compiled for law enforcement purposes; or<br>- Specifically relate to the participation in a civil action or other legal proceeding.<br><br>The Commission shall make its information and official records, to the extent, not otherwise designated in the Compact or by its rules, available to the public for inspection.<br><br>An executive committee is established which has the authority to act on behalf of the Commission, with the exception of rulemaking, when the Commission is not in session. The executive committee shall oversee the administration of the Compact, including enforcement and compliance with the Compact, its bylaws and rules, and other such duties as necessary.<br><br>The Commission may establish other committees for governance and administration of the Compact. |
| 12 | Powers and Duties of the Interstate Commission<br><br>*Recognizes creation of the Commission* | The Commission shall have the duties and the powers to:<br>- Oversee and administer the Compact;<br>- Promulgate rules, which are binding;<br>- Issue advisory opinions upon the request of member states concerning the meaning or interpretation of the Compact or its bylaws, rules, and actions;<br>- Enforce compliance with the Compact, provisions, the rules, and the bylaws;<br>- Establish and appoint committees, including the executive committee, which has the power to act on behalf of the Interstate Commission;<br>- Pay, or provide for the payment of Commission expenses;<br>- Establish and maintain one or more offices;<br>- Borrow, accept, hire, or contract for services of personnel;<br>- Purchase and maintain insurance and bonds;<br>- Employ an executive director with power to employ, select, or appoint employees, agents, or consultants, determine their qualifications and define their duties, and fix their compensation;<br>- Establish personnel policies and programs;<br>- Accept donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize and dispose of it consistent with conflict of interest policies as established by the Commission;<br>- Lease, purchase, accept contributions, or donation of, or otherwise own, hold, improve or use, any property, real, personal, or mixed;<br>- Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;<br>- Establish a budget and make expenditures; |

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | | - Adopt a seal and bylaws governing the management and operation of the Commission;<br>- Report annually to the legislatures and governors of the member states concerning the activities of the Commission during the preceding year, including reports of financial audits and any recommendations that may have been adopted by the Commission;<br>- Coordinate education, training, and public awareness regarding the Compact, its implementation and operation;<br>- Maintain records in accordance with the bylaws;<br>- Seek and obtain trademarks, copyrights, and patents; and<br>- Perform such functions as may be necessary or appropriate to achieve the purpose of the Compact. |
| 13 | Finance Powers<br><br>*Provides for annual assessment*<br><br>*Requires rule for any assessment*<br><br>*No pledging credit without authorization*<br><br>*Yearly audits* | The Compact authorizes an annual assessment levied on each member state to cover the costs of operations and activities of the Commission and its staff. The total assessment, subject to appropriation, must be sufficient to cover the amount not provided by other sources and needed to cover the annual budget approved each year by the Commission.<br><br>The Compact requires that the annual assessment must be allocated upon a formula to be determined by the Commission which shall promulgate a rule binding upon all the member states.<br><br>The Commission must not incur obligations of any kind prior to securing the funds adequate to meet the assessment.<br><br>The Commission is not authorized to pledge the credit of any of the member states, except by, and with the authority of, the member states.<br><br>The Compact requires yearly financial audits conducted by a certified or licensed public accountant and the report is to be included in the Commission's annual report. |
| 14 | Organization and Operation of the Interstate Commission<br><br>*Annual officer election* | The Compact creates a requirement for the Commission to adopt bylaws by a two-thirds (2/3) vote within twelve months of the first meeting which has already occurred. The first Bylaws were adopted in October 2015.[47]<br><br>A Chair, Vice Chair, and Treasurer shall be elected or appointed each year by the Commission.<br><br>Officers serve without remuneration. Officers and employees are immune from suit and liability, either personally or in their |

[47] Interstate Medical Licensure Compact, *Annual Report 2017,* https://imlcc.org/wp-content/uploads/2018/03/IMLCC-Annual-Report-2017-1.pdf (last visited Jan. 22, 2020).

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | *No officer remuneration*<br><br>*Liability protection for actions within scope of duties and responsibilities only for officers, employees, and agents* | professional capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, provided such person should not be protected from suit or liability for damage, loss, injury or liability caused by the intentional or willful and wanton conduct of such a person.<br><br>The liability of the executive director and Commission employees or representatives of the Commission, acting within the scope of their employment, may not exceed the limits set forth under the state's Constitution and laws for state officials, employees, and agents. The Compact provides that the Commission is considered an instrumentality of the state for this purpose.<br><br>The Compact provides that the Commission shall defend the executive director, its employees, and subject to the approval of the state's attorney general or other appropriate legal counsel, shall defend in any civil action seeking to impose liability within scope of duties.<br><br>The Compact provides that employees and representatives of the Commission shall be held harmless in the amount of any settlement or judgment, including attorney's fees and costs, that occurred within the scope of employment or responsibilities and not a result of intentional willful or wanton misconduct. |
| 15 | Rulemaking Functions of the Interstate Commission<br><br>*Promulgate reasonable rules*<br><br>*Judicial review at U.S. Federal District Court* | The Commission is required to promulgate reasonable rules in order to implement and operate the Compact and the Commission. The Compact adds that any attempt to exercise rulemaking beyond the scope of the Compact renders the action invalid. The rules should substantially conform to the "Model State Administrative Procedures Act" of 2010 and subsequent amendments thereto.<br><br>The Compact allows for judicial review of any promulgated rule. A petition may be filed thirty (30) days after a rule has been promulgated in the U.S. District Court in Washington, D.C., or the federal court where the Commission is located.[48] The Compact requests deference to the Commission's action consistent with state law. |

[48] The Interstate Medical Licensure Compact Commission is currently headquartered in Littleton, Colorado. *See* Interstate Medical License Commission, Facts about the IMLCC, https://imlcc.org/facts-about-the-imlcc/ (last visited Jan. 22, 2020).

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| 16 | Oversight of Interstate Compact<br><br>*Enforcement*<br><br>*Service of process* | The Compact is the responsibility of each state's own executive, legislative, and judicial branch to oversee and enforce. All courts are to take judicial notice of the Compact and any adopted administrative rules in a proceeding involving Compact subject matter.<br><br>The Compact provides that the Commission is entitled to receive service of process in any proceeding and shall have standing to intervene in any proceeding for all purposes. Failure to serve the Commission shall render a judgment or order void as to the Commission, the Compact, or promulgated rule. |
| 17 | Enforcement of Interstate Compact | The Compact provides the Commission reasonable discretion to enforce the provisions and rules of the Compact, including when and where to initiate legal action. The Commission is permitted to seek a range of remedies. |
| 18 | Default Procedures | The Compact provides a number of reasons a member state may default on the Compact, including failure to perform required duties and responsibilities and the options available to the Commission.<br><br>The Compact requires the Commission to promulgate rules to address how physician licenses are affected by the termination of a member state from the Compact. The rules must also ensure that a member state does not bear any costs when a state has been found to be in default.<br><br>The Compact provides an appeal process for the terminating state and procedures for attorney's fees and costs. |
| 19 | Dispute Resolution | The Compact authorizes the Commission to use dispute resolution tools to resolve disputes between states, such as mediation and binding dispute resolution. The Commission shall promulgate rules for the dispute resolution process. |
| 20 | Member States, Effective Date and Amendment | The Compact allows any state to become a member state and that the Compact is binding upon the legislative enactment of the Compact by no less than seven (7) states.[49] |
| 21 | Withdrawal | A member state may withdraw from the Compact through repeal of this section of law which inserted the Compact into state statute. Any repeal of the Compact through repeal of the state law cannot take effect until one (1) year after the effective date of such an |

[49] The Compact is in force now. The Commission was seated for the first time in October 2015 and issued its first letters of qualification to physicians in April 2017. *See* Interstate Medical Licensure Compact, https://imlcc.org/faqs/ (last visited Jan. 22, 2020).

| Provisions of the Interstate Medical Licensure Compact | | |
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| **Section** | **Title** | **Description** |
| | | action and written notice has been given by the withdrawing state to the governor of each other member state.<br><br>The Compact provision also requires that upon introduction of any repeal legislation, that the withdrawing state immediately notify the Chairperson of the Commission of the legislation.<br><br>The Compact provides that it is the Commission's responsibility to notify the other member states within 60 (sixty) days of its receipt of information about legislation that would repeal that state's participation in the Compact. The withdrawing state would be responsible for any dues, obligations, or liabilities incurred through the date of withdrawal. Reinstatement is an option under the Compact.<br><br>The Compact authorizes the Commission to develop rules to address the impact of the withdrawal of a member state on licenses. |
| 22 | Dissolution | When the membership of the Compact is reduced to one, the Compact shall be dissolved. Once dissolved, the Compact shall be null and void.<br><br>Once concluded, any surplus funds of the Commission shall be distributed in accordance with the bylaws. |
| 23 | Severability and Construction | If any part of this Compact is not enforceable, the remaining provisions are still enforceable.<br><br>The provisions of the Compact are to be liberally construed, and nothing is to be construed so as to prohibit the applicability of other interstate compacts to which states might be members. |
| 24 | Binding Effect of Compact and Other Laws | This Compact does not prohibit the enforcement of other laws which are not in conflict with this Compact. All laws which are in a member state which are inconsistent with this Compact are superseded to the point of the contact.<br><br>The actions of the Commission are binding on the member states, including all promulgated rules and the adopted bylaws of the Commission. All agreements between the Commission and the member state are binding in accordance with their terms.<br><br>In the event that any provision of this Compact exceeds Florida's constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent that the conflict of the constitutional provision in question in that member state. |

**Section 8** creates section 456.4502, F.S. to require a formal hearing be held before the Division of Administrative Hearings if there are any disputed issues of material fact when the licenses of certain physicians and osteopathic physicians are suspended or revoked by this state under the Compact; requiring the DOH to notify the division of a petition for a formal hearing within a specified timeframe; requiring the administrative law judge to issue a recommended order; requiring the Board of Medicine or the Board of Osteopathic Medicine, as applicable, to determine and issue final orders in certain cases; providing the DOH with standing to seek judicial review of any final order of the boards;

**Section 9** creates section 456.4504, F.S., to authorize the DOH to adopt rules to implement the Compact.

**Section 10** amends section 768.28, F.S., to designate the representative appointed from the Board of Medicine and the representative appointed from the Board of Osteopathic Medicine, when serving as commissioners of the Commission and any administrator, officer, executive director, employee, or representative of the Commission, when acting within the scope of their employment, duties, or responsibilities in this state, are considered agents of the state, for the purpose of applying sovereign immunity and waivers of sovereign immunity. This section also requires the Commission to pay certain claims or judgments and authorizes the Commission to maintain insurance coverage to pay such claims or judgments.

**Section 11** provides an effective date of July 1, 2021.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

None.

### B. Public Records/Open Meetings Issues:

The Interstate Commission requires most of its meetings to be open to the public. The notice requirements vary depending on the purpose of the meeting, however. Rulemaking hearings, where rules are proposed in a manner substantially similar to the model state administrative procedure act of 2010, are submitted to the Bylaws and Rules Committee for review and action. Prior to final consideration by the Commission, the final proposed rule must be publicly noticed on the Commission's website or other agreed upon distribution site at least 30 days prior to the meeting at which the vote is scheduled.[50] A reason for the proposed rule action will also be posted.[51] The public must also be provided a reasonable opportunity to provide public comment, orally or in writing, for proposed rules. A committee of the Commission may propose a rule at any time by a majority vote of that committee.

[50] Interstate Medical Licensure Commission, *Rule on Rulemaking* (Adopted June 24, 2016), *Rule 1.4(c)*, https://imlcc.org/wp-content/uploads/2018/02/IMLCC-Rule-Chapter-1-Rule-on-Rulemaking-Adopted-June-24-2016.pdf (last visited Jan. 23, 2020).
[51] *Id.*, Rule 1.4(b).

The written procedure states for every proposed rule action that there will also be instruction on how interested parties may attend the scheduled public hearing, may submit their intent to attend the public hearing and submit any written comments.[52] A transcript of these meetings are not made unless one is specifically requested and then the requestor is responsible for the cost the transcription.[53]

Not later than 30 days after its adoption, any interested party may petition for judicial review of the rule in the United States District Court for the District of Columbia or in the federal court where the Commission's headquarters are currently located. The Commission's mailing address currently is in Littleton, Colorado.[54]

The Compact also permits the Commission, with a two-thirds vote of the Commissioners present, to meet in closed, nonpublic meetings if the Commission must address any matters that:

- Relate solely to the internal personnel practices and procedures of the Interstate Commission.
- Specifically exempted from disclosure by federal statute;
- Discuss trade secrets, commercial, or financial information that is privileged or confidential;
- Involve accusing a person of a crime, or formally censuring a person;
- Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Discuss investigative records compiled for law enforcement purposes; or
- Specifically relate to the participation in a civil action or other legal proceeding.[55]

The rulemaking process, its timelines and public involvement process, plus the closure of public meetings for some of these detailed reasons, may be inconsistent with Florida law on public meetings.

While the provisions of the Compact and its administrative rules and corporate bylaws require minutes to be kept of some of these closed sessions, it is not clear that it is applicable to all closed sessions and it does require an interested party to request a transcriber in some cases to be present and to expend personal funds to ensure the availability of minutes. A third party may or may not be as likely either to fully describe all matters discussed and provide an accurate summary of actions taken, including a record of any roll call votes.[56]

According to the Commission's Bylaws, the public notice for a regular meeting of the Commission is at least 10 days prior to the meeting according to the Compact and the notice will be posted on the Commission's website or distributed through another website

[52] *Id.*, Rule 1.4(d).
[53] *Id.*, Rule 1.4(e).
[54] Interstate Medical License Commission, Facts about the IMLCC, https://imlcc.org/facts-about-the-imlcc/ (last visited Jan. 22, 2020).
[55] Interstate Medical License Compact Bylaws, *Section 11 – Interstate Medical License Compact Commission, Section (h)-(l),* https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Jan. 22, 2020).
[56] *Id.*

designated by the Commission for interested parties to receive notice who have requested to receive such notices.[57]

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

Article VII, Section 19, of the State Constitution requires that a new state tax or fee, as well as an increased state tax or fee, must be approved by two-thirds of the membership of each house of the Legislature and must be contained in a separate bill that contains no other subject. Article VII, Section 19(d)(1) of the State Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."

Under the bill, the Compact assesses and collect fees from allopathic and osteopathic physicians who elect to participate in the expedited licensure process.

For physicians who elect this license, a non-refundable service fee of $700 for the letter of qualification is charged to the applicant by the Commission when the initial application is submitted to the Commission. Of that $700, $300 is remitted to the applicant's home state or state of principal licensure and the remaining $400 is sent to the Commission's general fund.

Every time the applicant requests that a letter of qualification be disseminated to one or more of the member states that participate in the Compact after the initial dissemination of the letter for the expedited license, the cost to the registrant is $100. Of this amount, one hundred percent is sent to the Commission's General Fund.

For each expedited license that is renewed through the Compact, a non-refundable fee of $25 shall be assessed to the physician and paid to the Commission General Fund. The Commission receives 100 percent of these funds.

In light of the increase in fees necessary for licensure as a physician through the Compact and the new fee for an expedited license, a separate, linked fee bill should be considered.

E. Other Constitutional Issues:

The Compact authorizes Compact administrators to develop rules that member states must adopt, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the Commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative authority to prospectively adopt federal statutes

[57] *Id.*

not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[58,59] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be Florida case law that squarely addresses this issue in the context of interstate compacts.

The most recent case Florida courts have had to address this issue was in *Department of Children and Family Services v. L.G.,* involving the Interstate Compact for the Placement of Children (ICPC).[60] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the ICPC were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact."[61] The court states that "the precise legal effect of the ICPC administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[62] However, in a footnote, the court said:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,*

[58] *Freimuth v. State,* 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel Orange State Oil Co.,* 155 Fla. 772 (1945).
[59] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State,* 723 So.2d 199 (Fla. 1998).
[60] 801 So.2d 1047 (Fla. 1st DCA 2001).
[61] Id at 1052.
[62] *Id.*

398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[63]

In accordance with that footnote, the bill's delegation of rule-making authority to the Commission is similar to the delegation to the ICPC administrators, and thus could constitute an unlawful delegation of legislative authority. The referenced case, however, does not appear to be binding as precedent since the court's footnote discussion is dicta.[64]

## V. Fiscal Impact Statement:

### A. Tax/Fee Issues:

None.

### B. Private Sector Impact:

SB 926 could lead to more licensed allopathic physicians and osteopathic physicians practicing in Florida. The fiscal result to the private sector is indeterminate.

### C. Government Sector Impact:

The Department of Health (DOH) will see a recurring, indeterminate decrease in revenue due to the loss of the mandated 10 percent fine on student loan default cases that is removed under the bill. In addition, the department will experience a recurring increase in revenues associated with the multistate application, initial, renewal and upgrade fees through the Interstate Medical Licensure Compact (IMLC). There are currently 29 member states. The increase of applications in Florida is unknown; therefore, fiscal impact is indeterminate. [65]

The DOH will experience a recurring increase in workload associated with processing applications and issuing initial and renewal licenses to participate in the IMLC. The DOH projects needing a minimum of three (3) full-time equivalent (FTE) positions with a projected cost of $152,280, ($138,993 in recurring costs and $13,287 in nonrecurring costs) to support the workload increase. In addition, the DOH may experience a recurring increase in workload associated with the additional complaints and investigations due to the new IMLC license. The impact is indeterminate; therefore, the fiscal impact cannot be calculated at this time.[66]

The DOH will update the Licensing and Enforcement Information Database System to accommodate the new IMLC license that can be absorbed within existing resources. The DOH may experience a recurring increase in cost related to the annual membership with

[63] *Id.*
[64] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no biding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).
[65] Florida Department of Health, Agency Analysis of SB 926 (January 10, 2020 on file with the Senate Appropriations Subcommittee on Health and Human Services).
[66] *Id.*

the IMLC; however, it is anticipated that current budget authority is adequate to absorb. Also, the DOH will incur nonrecurring costs for rulemaking that can be absorbed within existing resources.[67]

The Florida Department of Law Enforcement (FDLE) may also experience an indeterminate negative fiscal impact from criminal history records checks and fingerprint retention that could result from the passage of the Compact.[68] The FDLE has indicated that the impact of this bill alone does not necessitate additional FTE or other resources.[69]

The bill may somewhat increase the caseload at the Division of Administrative Hearings. The number of disciplined physicians who would pursue this legal path to recover their licenses is indeterminate.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.0635, 456.072, 456.074, and 768.28.

This bill creates the following sections of the Florida Statutes: 458.3129, 459.074, 456.4501, 456.4502, and 456.4504.

This bill repeals section 456.0721 of the Florida Statutes.

## IX. Additional Information:

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

None.

B. Amendments:

None.



[67] *Id.*
[68] Florida Department of Law Enforcement *Senate Bill 926 Agency Analysis* (Nov. 25, 2019) (on file with Senate Committee on Health Policy).
[69] *Id.*

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

**JOINT COMMITTEE:**
Joint Committee on Public Counsel Oversight

**SENATOR GAYLE HARRELL**
25th District

January 28, 2020

Senator Aaron Bean
405 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Bean,

I respectfully request that **SB 926 – Health Care Practitioner Licensure** be placed on the next available agenda for the Appropriations Subcommittee on Health and Human Services Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

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

**BILL GALVANO**
**President of the Senate**

**DAVID SIMMONS**
**President Pro Tempore**

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

02/25/2020
*Meeting Date*

SB 0926
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Health Care Practitioner Licensure.

Name Ivonne Fernandez

Job Title Associate State Director

Address 215 South Monroe Street
*Street*

Phone 954-850-7262

Tallahassee FL
*City* *State* *Zip*

Email ifernandez@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

**By** Senator Harrell

25-01035C-20 2020926__

A bill to be entitled

An act relating to health care practitioner licensure; creating s. 458.3129, F.S.; establishing that a physician licensed under the Interstate Medical Licensure Compact is deemed to be licensed under chapter 458; creating s. 459.074, F.S.; establishing that an osteopathic physician licensed under the Interstate Medical Licensure Compact is deemed to be licensed under chapter 459; amending s. 456.0635, F.S.; removing the requirement that each board within the jurisdiction of the Department of Health, or the department if there is no board, prohibit a candidate from being examined for or issued, or having renewed a license, certificate, or registration to practice a health care profession if he or she is listed on a specified federal list of excluded individuals and entities; amending s. 456.072, F.S.; deleting a provision classifying the failure to repay a student loan issued or guaranteed by the state or federal government in accordance with the terms of the loan as a failure to perform a statutory or legal obligation; removing penalties; repealing s. 456.0721, F.S., relating to investigations of health care practitioners in default on student loan or scholarship obligations; amending s. 456.074, F.S.; deleting the requirement, and related provisions, that the department immediately suspend the licenses of certain health care practitioners for failing to provide proof of new payment terms for defaulted







25-01035C-20 2020926__

student loans within a specified timeframe; creating s. 456.4501, F.S.; implementing the Interstate Medical Licensure Compact in this state; providing for an interstate medical licensure process; providing requirements for multistate practice; creating s. 456.4502, F.S.; establishing that a formal hearing before the Division of Administrative Hearings must be held if there are any disputed issues of material fact when the licenses of certain physicians and osteopathic physicians are suspended or revoked by this state under the compact; requiring the department to notify the division of a petition for a formal hearing within a specified timeframe; requiring the administrative law judge to issue a recommended order; requiring the Board of Medicine or the Board of Osteopathic Medicine, as applicable, to determine and issue final orders in certain cases; providing the department with standing to seek judicial review of any final order of the boards; creating s. 456.4504, F.S.; authorizing the department to adopt rules; amending s. 768.28, F.S.; designating the state commissioners of the Interstate Medical Licensure Compact Commission and other members or employees of the commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain insurance coverage to pay such claims or judgments; providing an effective date.

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

Section 1. Section 458.3129, Florida Statutes, is created to read:

458.3129 Interstate Medical Licensure Compact.—A physician licensed to practice medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 2. Section 459.074, Florida Statutes, is created to read:

459.074 Interstate Medical Licensure Compact.—A physician licensed to practice osteopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 3. Subsection (2) and paragraph (e) of subsection (3) of section 456.0635, Florida Statutes, are amended to read:

456.0635 Health care fraud; disqualification for license, certificate, or registration.—

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the candidate or applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the candidate or applicant has successfully completed a pretrial diversion or drug court program for that felony and provides





proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application;

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application;

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application~~; or~~

~~(c) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities~~.

This subsection does not apply to an applicant for initial licensure, certification, or registration who was arrested or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

(3) The department shall refuse to renew a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

~~(c) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.~~

This subsection does not apply to an applicant for renewal of licensure, certification, or registration who was arrested or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

Section 4. Paragraph (k) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(k) Failing to perform any statutory or legal obligation placed upon a licensee. ~~For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the~~





~~Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations shall be considered a failure to perform a statutory or legal obligation, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.~~

Section 5. Section 456.0721, Florida Statutes, is repealed.

Section 6. Subsection (4) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.—

~~(4) Upon receipt of information that a Florida-licensed health care practitioner has defaulted on a student loan issued or guaranteed by the state or the Federal Government, the department shall notify the licensee by certified mail that he or she shall be subject to immediate suspension of license unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The department shall issue an emergency order suspending the license of any licensee who, after 45 days following the date of mailing from the department, has failed to provide such proof. Production of such proof shall not prohibit the department from proceeding with disciplinary action against the licensee pursuant to s. 456.073.~~

Section 7. Section 456.4501, Florida Statutes, is created

to read:

456.4501 Interstate Medical Licensure Compact.—The Interstate Medical Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

SECTION 1
PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The Compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the Compact.





SECTION 2
DEFINITIONS

In this compact:

(a) "Bylaws" means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance, or for directing and controlling its actions and conduct.

(b) "Commissioner" means the voting representative appointed by each member board pursuant to Section 11.

(c) "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(d) "Expedited License" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the Compact.

(e) "Interstate Commission" means the interstate commission created pursuant to Section 11.

(f) "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(g) "Medical Practice Act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(h) "Member Board" means a state agency in a member state that acts in the sovereign interests of the state by protecting

the public through licensure, regulation, and education of physicians as directed by the state government.

(i) "Member State" means a state that has enacted the Compact.

(j) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.

(k) "Physician" means any person who:

(1) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(2) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(3) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(4) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; however, the specialty certification or a time-unlimited specialty certificate does not





have to be maintained once a physician is initially determined to be eligible for expedited licensure through the Compact;

(5) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(6) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(7) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;

(8) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(9) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(l) "Offense" means a felony, high court misdemeanor, or crime of moral turpitude.

(m) "Rule" means a written statement by the Interstate Commission promulgated pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule.

(n) "State" means any state, commonwealth, district, or territory of the United States.

(o) "State of Principal License" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.

SECTION 3
ELIGIBILITY

(a) A physician must meet the eligibility requirements as defined in Section 2(k) to receive an expedited license under the terms and provisions of the Compact.

(b) A physician who does not meet the requirements of Section 2(k) may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the Compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4
DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the Compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(1) The state of primary residence for the physician, or

(2) The state where at least 25% of the practice of





medicine occurs, or

(3) The location of the physician's employer, or

(4) If no state qualifies under subsection (1), subsection (2), or subsection (3), the state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, as long as the state meets the requirements in subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5
APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(a) A physician seeking licensure through the Compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(1) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, shall not

be subject to additional primary source verification where already primary source verified by the state of principal license.

(2) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with U.S. 5 C.F.R. s. 731.202.

(3) Appeal on the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of that state.

(c) Upon verification in subsection (b), physicians eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (a), including the payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) and any fees under subsection (c), a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full



and unrestricted license within the member state.

(f) An expedited license obtained through the Compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

SECTION 6
FEES FOR EXPEDITED LICENSURE

(a) A member state issuing an expedited license authorizing the practice of medicine in that state, or the regulating authority of the member state, may impose a fee for a license issued or renewed through the Compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited licenses. However, those rules shall not limit the authority of a member state, or the regulating authority of the member state, to impose and determine the amount of a fee under subsection (a).

SECTION 7
RENEWAL AND CONTINUED PARTICIPATION

(a) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(1) Maintains a full and unrestricted license in a state of

principal license;

(2) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(3) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; and

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(c) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(d) Upon receipt of any renewal fees collected in subsection (c), a member board shall renew the physician's license.

(e) Physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(f) The Interstate Commission is authorized to develop rules to address renewal of licenses obtained through the Compact.

SECTION 8

COORDINATED INFORMATION SYSTEM







(a) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the Compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any non-public complaint, disciplinary, or investigatory information not required by subsection (c) to the Interstate Commission.

(e) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9

JOINT INVESTIGATIONS

(a) Licensure and disciplinary records of physicians are

deemed investigative.

(b) In addition to the authority granted to a member board by its respective Medical Practice Act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(c) A subpoena issued by a member state shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

(e) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10

DISCIPLINARY ACTIONS

(a) Any disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state.

(b) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any



member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the Medical Practice Act of that state.

(c) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(1) Impose the same or lesser sanction(s) against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or

(2) Pursue separate disciplinary action against the physician under its respective Medical Practice Act, regardless of the action taken in other member states.

(d) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license(s) issued to the physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act of that state.

SECTION 11

INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(a) The member states hereby create the "Interstate Medical Licensure Compact Commission."

(b) The purpose of the Interstate Commission is the administration of the Interstate Medical Licensure Compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the Compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the Compact.

(d) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as Commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint one representative from each member board. A Commissioner shall be a(n):

(1) Allopathic or osteopathic physician appointed to a member board;

(2) Executive director, executive secretary, or similar executive of a member board; or

(3) Member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting shall be a business



meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each Commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of Commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subsection (d).

(h) The Interstate Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that an open meeting would be likely to:

(1) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(2) Discuss matters specifically exempted from disclosure by federal statute;

(3) Discuss trade secrets, commercial, or financial information that is privileged or confidential;

(4) Involve accusing a person of a crime, or formally censuring a person;

(5) Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(6) Discuss investigative records compiled for law enforcement purposes; or

(7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes which shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the Compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the Compact including enforcement and compliance with the provisions of the Compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission may establish other committees for governance and administration of the Compact.

SECTION 12







POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission shall have the duty and power to:

(a) Oversee and maintain the administration of the Compact;

(b) Promulgate rules which shall be binding to the extent and in the manner provided for in the Compact;

(c) Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the Compact, its bylaws, rules, and actions;

(d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

(e) Establish and appoint committees including, but not limited to, an executive committee as required by Section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(f) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(g) Establish and maintain one or more offices;

(h) Borrow, accept, hire, or contract for services of personnel;

(i) Purchase and maintain insurance and bonds;

(j) Employ an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation;

(k) Establish personnel policies and programs relating to

conflicts of interest, rates of compensation, and qualifications of personnel;

(l) Accept donations and grants of money, equipment, supplies, materials and services, and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use, any property, real, personal, or mixed;

(n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(o) Establish a budget and make expenditures;

(p) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(q) Report annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports shall also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission;

(r) Coordinate education, training, and public awareness regarding the Compact, its implementation, and its operation;

(s) Maintain records in accordance with the bylaws;

(t) Seek and obtain trademarks, copyrights, and patents; and

(u) Perform such functions as may be necessary or appropriate to achieve the purposes of the Compact.

SECTION 13



FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment, subject to appropriation, must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(d) The Interstate Commission shall be subject to a yearly financial audit conducted by a certified or licensed public accountant and the report of the audit shall be included in the annual report of the Interstate Commission.

SECTION 14

ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall, by a majority of Commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the Compact within twelve (12) months of the first

Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its Commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers selected in subsection (b) shall serve without remuneration from the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(1) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states





for the purposes of any such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(2) The Interstate Commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(3) To the extent not covered by the state involved, member state, or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from

intentional or willful and wanton misconduct on the part of such persons.

SECTION 15

RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules deemed appropriate for the operations of the Interstate Commission shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(c) Not later than thirty (30) days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be





unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16

OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of the Compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the Compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the Compact, or promulgated rules.

SECTION 17

ENFORCEMENT OF INTERSTATE COMPACT

(a) The Interstate Commission, in the reasonable exercise

of its discretion, shall enforce the provisions and rules of the Compact.

(b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal action in the United States District Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

(c) The remedies herein shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 18
DEFAULT PROCEDURES

(a) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the Compact, or the rules and bylaws of the Interstate Commission promulgated under the Compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the Compact, or the bylaws or promulgated





rules, the Interstate Commission shall:

(1) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

(2) Provide remedial training and specific technical assistance regarding the default.

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the Compact upon an affirmative vote of a majority of the Commissioners and all rights, privileges, and benefits conferred by the Compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(d) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination including obligations,

the performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the Compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

SECTION 19
DISPUTE RESOLUTION

(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the Compact and which may arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20
MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(a) Any state is eligible to become a member state of the





Compact.

(b) The Compact shall become effective and binding upon legislative enactment of the Compact into law by no less than seven (7) states. Thereafter, it shall become effective and binding on a state upon enactment of the Compact into law by that state.

(c) The governors of non-member states, or their designees, shall be invited to participate in the activities of the Interstate Commission on a non-voting basis prior to adoption of the Compact by all states.

(d) The Interstate Commission may propose amendments to the Compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21
WITHDRAWAL

(a) Once effective, the Compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the Compact by specifically repealing the statute which enacted the Compact into law.

(b) Withdrawal from the Compact shall be by the enactment of a statute repealing the same, but shall not take effect until one (1) year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(c) The withdrawing state shall immediately notify the

chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the Compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection (c).

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the Compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22
DISSOLUTION

(a) The Compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the Compact to one (1) member state.

(b) Upon the dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate



Commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23
SEVERABILITY AND CONSTRUCTION

(a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of the Compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the Compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24
BINDING EFFECT OF COMPACT AND OTHER LAWS

(a) Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.

(b) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(e) In the event any provision of the Compact exceeds the

constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 8. Section 456.4502, Florida Statutes, is created to read:

456.4502 Interstate Medical Licensure Compact; disciplinary proceedings.—A physician licensed pursuant to chapter 458, chapter 459, or s. 456.4501 whose license is suspended or revoked by this state pursuant to the Interstate Medical Licensure Compact as a result of disciplinary action taken against the physician's license in another state shall be granted a formal hearing before an administrative law judge from the Division of Administrative Hearings held pursuant to chapter 120 if there are any disputed issues of material fact. In such proceedings:

(a) Notwithstanding s. 120.569(2), the department shall notify the division within 45 days after receipt of a petition or request for a formal hearing.

(b) The determination of whether the physician has violated the laws and rules regulating the practice of medicine or osteopathic medicine, as applicable, including a determination of the reasonable standard of care, is a conclusion of law that is to be determined by appropriate board, and is not a finding of fact to be determined by an administrative law judge.

(c) The administrative law judge shall issue a recommended order pursuant to chapter 120.

(d) The Board of Medicine or the Board of Osteopathic Medicine, as applicable, shall determine and issue the final







order in each disciplinary case. Such order shall constitute final agency action.

(e) Any consent order or agreed-upon settlement is subject to the approval of the department.

(f) The department shall have standing to seek judicial review of any final order of the board, pursuant to s. 120.68.

Section 9. Section 456.4504, Florida Statutes, is created to read:

456.4504 Interstate Medical Licensure Compact Rules.—The department may adopt rules to implement the Interstate Medical Licensure Compact.

Section 10. Paragraph (h) is added to subsection (10) of section 768.28, Florida Statutes, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(h) For the purposes of this section, the representative appointed from the Board of Medicine and the representative appointed from the Board of Osteopathic Medicine, when serving as commissioners of the Interstate Medical Licensure Compact Commission pursuant to s. 456.4501, and any administrator, officer, executive director, employee, or representative of the Interstate Medical Licensure Compact Commission, when acting within the scope of their employment, duties, or responsibilities in this state, are considered agents of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any

such claims or judgments.

Section 11. This act shall take effect July 1, 2021.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1094 |
| INTRODUCER: | Health Policy Committee and Senator Diaz |
| SUBJECT: | Consultant Pharmacists |
| DATE: | February 24, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Rossitto-Van Winkle | Brown | HP | **Fav/CS** |
| 2. | Howard | Kidd | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1094 expands the scope of practice of professional pharmacists to include:

- Ordering and evaluating any laboratory or clinical testing;
- Conducting patient assessments;
- Modifying, discontinuing, or administering medicinal drugs pursuant to s. 465.0125, F.S. by a consultant pharmacist; and
- Conducting "other pharmaceutical services," which includes reviewing and making recommendations regarding the patient's drug therapy and health care status to a patient's prescribing physician, podiatrist, or dentist regarding the patient's drug therapy and health care status.

The bill authorizes a consultant pharmacist to enter into a written collaborative practice agreement (CPA) with a health care facility medical director, or Florida-licensed physician, podiatrist, or dentist, who is authorized to prescribe medication. The bill also expands the locations where, under a CPA, a consultant pharmacist may offer his or her services, to include:

- Ambulatory surgical center;
- Inpatient hospice;
- Hospital;
- Alcohol or chemical dependency treatment center;
- Ambulatory care center; or

- Nursing home or nursing home within a continuing care facility.

A consultant pharmacist may only provide services to the patients of the health care practitioner with whom the consultant pharmacist has a written collaborative practice agreement. The bill requires both the consultant pharmacist and health care practitioner to maintain a copy of the collaborative agreement and make it available upon request or during an inspection. The bill also requires the consultant pharmacist to maintain all drug, patient care, and quality assurance records.

The bill has an insignificant fiscal impact on the Department of Health (department) that can be absorbed within existing resources.

The bill provides an effective date of July 1, 2020.

## II. Present Situation:

### Pharmacist Licensure

Pharmacy is the third largest health profession behind nursing and medicine.[1] The Board of Pharmacy (Board), in conjunction with the Department of Health (department), regulates the practice of pharmacists pursuant to ch. 465, F.S.[2] To be licensed as a pharmacist, a person must:[3]

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;[4]
- Have completed a Board-approved internship; and
- Successfully complete the Board-approved examination.

A pharmacist must complete at least 30 hours of Board-approved continuing education during each biennial renewal period.[5] Pharmacists who are certified to administer vaccines or epinephrine auto-injections must complete a three-hour continuing education course on the safe and effective administration of vaccines and epinephrine auto-injections as a part of the biennial licensure renewal.[6] Pharmacists who administer long-acting antipsychotic medications must complete an approved eight-hour continuing education course as a part of the continuing education for biennial licensure renewal.[7]

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[1] American Association of Colleges of Pharmacy, *About AACP*, *available at* https://www.aacp.org/about-aacp (last visited Feb. 6, 2020).
[2] Sections 465.004 and 465.005, F.S.
[3] Section 465.007, F.S. The department may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[4] If the applicant has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, the applicant must demonstrate proficiency in English, pass the board-approved Foreign Pharmacy Graduate Equivalency Examination, and complete a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a department-licensed pharmacist.
[5] Section 465.009, F.S.
[6] Section 465.009(6), F.S.
[7] Section 465.1893, F.S.

***Pharmacist Scope of Practice***

In Florida, the practice of the profession of pharmacy includes:[8]

- Compounding, dispensing, and consulting concerning the contents, therapeutic values, and uses of any medicinal drug;
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations;
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy, including the review of the patient's drug therapy and communication with the patient's prescribing health care provider or other persons specifically authorized by the patient, regarding the drug therapy;
- Transmitting information from prescribers to their patients;
- Administering vaccines to adults;[9]
- Administering epinephrine autoinjections;[10] and
- Administering antipsychotic medications by injection.[11]

A pharmacist may not alter a prescriber's directions, diagnose or treat any disease, initiate any drug therapy, or practice medicine or osteopathic medicine, unless permitted by law.[12]

Pharmacists may order and dispense drugs that are included in a formulary developed by a committee composed of members of the Board of Medicine, the Board of Osteopathic Medicine, and the Board of Pharmacy.[13] The formulary may only include:[14]

- Any medicinal drug of single or multiple active ingredients in any strengths when such active ingredients have been approved individually or in combination for over-the-counter sale by the U.S. Food and Drug Administration (FDA);
- Any medicinal drug recommended by the FDA Advisory Panel for transfer to over-the-counter status pending approval by the FDA;
- Any medicinal drug containing any antihistamine or decongestant as a single active ingredient or in combination;
- Any medicinal drug containing fluoride in any strength;
- Any medicinal drug containing lindane in any strength;
- Any over-the-counter proprietary drug under federal law that has been approved for reimbursement by the Florida Medicaid Program; and
- Any topical anti-infectives excluding eye and ear topical anti-infectives.

A pharmacist may order, within his or her professional judgment, and subject to the stated following stated conditions:

- Certain oral analgesics for mild to moderate pain. The pharmacist may order these drugs for minor pain and menstrual cramps for patients with no history of peptic ulcer disease. The prescription is limited to a six day supply for one treatment of:

[8] Section 465.003(13), F.S.
[9] *See* s. 465.189, F.S.
[10] *Id.*
[11] Section 465.1893, F.S.
[12] Section 465.003(13), F.S.
[13] Section 465.186, F.S.
[14] *Id.*

  - Magnesium salicylate/phenyltoloxamine citrate;
  - Acetylsalicylic acid (Zero order release, long acting tablets);
  - Choline salicylate and magnesium salicylate;
  - Naproxen sodium;
  - Naproxen;
  - Ibuprofen;
  - Phenazopyridine, for urinary pain; and
  - Antipyrine 5.4%, benzocaine 1.4%, glycerin, for ear pain if clinical signs or symptoms of tympanic membrane perforation are not present;
- Anti-nausea preparations;
- Certain antihistamines and decongestants;
- Certain topical antifungal/antibacterials;
- Topical anti-inflammatory preparations containing hydrocortisone not exceeding 2.5%;
- Otic antifungal/antibacterial;
- Salicylic acid 16.7% and lactic acid 16.7% in flexible collodion, to be applied to warts, except for patients under 2 years of age, and those with diabetes or impaired circulation;
- Vitamins with fluoride, excluding vitamins with folic acid in excess of 0.9 mg.;
- Medicinal drug shampoos containing Lindane for the treatment of head lice;
- Ophthalmics. Naphazoline 0.1% ophthalmic solution;
- Certain histamine H2 antagonists;
- Acne products; and
- Topical Antiviral for herpes simplex infections of the lips.[15]

***Consultant Pharmacists***

A consultant pharmacist is a pharmacist who provides expert advice on the use of medications to individuals and older adults.[16] To be licensed as a consultant pharmacist, an applicant must:[17]

- Hold a license as a pharmacist that is active and in good standing;
- Successfully complete an approved consultant pharmacist course of at least 12 hours;[18] and
- Successfully complete a 40-hour period of assessment and evaluation under the supervision of a preceptor within one year of completion of an approved consultant pharmacist course.

***Education and Training Requirements for Consultant Pharmacists***

In addition to the training and education received as a part of a degree program in pharmacy, a consultant pharmacist is required to complete a consultant pharmacy course and a period of assessment and evaluation under the supervision of a preceptor. The Board has general rulemaking authority to adopt rules to implement the pharmacy practice act and specific

[15] Fla. Admin. Code R. 64B16-27.220 (2019).
[16] American Society of Consultant Pharmacists, *What is a Senior Care Pharmacist,* available at http://www.ascp.com/page/whatisacp (last visited Feb. 6, 2020). Consultant pharmacists are often referred to as "senior care pharmacist."
[17] Fla. Admin. Code R. 64B16-26.300, (2019).
[18] Fla. Admin. Code R. 64B16-26.300, (2019) requires the course to be sponsored by an accredited college of pharmacy and approved by the Florida Board of Pharmacy Tripartite Continuing Education Committee which is based on the Statement of the Competencies Required in Institutional Pharmacy Practice and subject matter set forth in Fla. Adm. Code R. 64B16-26.301(2019).

authority to adopt rules related to the licensure of consultant pharmacists.[19] The Board does not have specific authority to adopt rules related to the educational requirements for consultant pharmacists. Regardless, the Board has, by rule, established the minimum educational and training requirements for licensure as a consultant pharmacist.[20]

The Board has specified the topics on which a consultant pharmacist may be trained in order to qualify for the designation. The consultant pharmacy course must provide at least 12 hours of education in the following areas:[21]

- Laws and rules including state and federal laws and regulations pertaining to health care facilities, institutional pharmacy, safe and controlled storage of alcohol and other related substances, and fire and health-hazard control;
- Policies and procedures outlining the medication system in effect and record-keeping for controlled substance control and record of usage, medication use evaluation, medication errors, statistical reports, etc.;
- Fiscal controls;
- Personnel management, including intra-professional relations pertaining to medication use and inter-professional relations with other members of the institutional health care team to develop formularies, review medication use and prescribing, and the provision of in-service training of other members of the institutional health care team;
- Professional responsibilities, including:
  - Drug information retrieval and methods of dispersal;
  - Development of pharmacy practice;
  - Development of an IV Admixture service;
  - Procedures to enhance medication safety, including availability of equipment and techniques to prepare special dosage forms for pediatric and geriatric patients, safety of patient self-medication and control of drugs at bedside, reporting and trending adverse drug reactions, screening for potential drug interactions, and proper writing, initiating, transcribing and/or transferring patient medication orders;
  - Maintenance of drug quality and safe storage;
  - Maintenance of drug identity.
- The institutional environment, including the institution's pharmacy function and purpose, understanding the scope of service and in-patient care mission of the institution, and interdepartmental relationships important to the institutional pharmacy; and
- Nuclear pharmacy, including procurement, compounding, quality control procedures, dispensing, distribution, basic radiation protection and practices, consultation and education to the nuclear medical community, record-keeping, reporting adverse drug reactions and medication errors, and screening for potential drug interactions.

The applicant must score a passing grade on the course examination for certification of successful completion.[22]

[19] Section 465.005, F.S.
[20] Fla. Admin. Code R. 64B16-26.300,(2019).
[21] Fla. Admin. Code R. 64B16-26.300 and 64B16-26.301(2019).
[22] *Id.*

A consultant pharmacist must successfully complete a period of assessment and evaluation, under the supervision of a qualified preceptor, within one year of completing the consultant pharmacy educational course.[23] The period of assessment and evaluation must be completed within three consecutive months and include at least 40 hours of training in the following practice areas:[24]

- Twenty-four hours on regimen review, documentation, and communication;
- Eight hours on facility review, including the ability to demonstrate areas that should be evaluated, documentation, and reporting procedures;
- Two hours on committee and reports, including the review of quarterly quality of care committee minutes and preparation and delivery of the pharmacist quarterly report;
- Two hours on policy and procedures, including preparation, review, and updating Policy and Methods;
- Two hours on principles of formulary management; and
- Two hours on professional relationships, including knowledge and interaction of facility administration and professional staff.

At least 60 percent of this training must occur on-site at an institution that holds a pharmacy permit.[25]

***Scope of Practice***

The scope of practice for a consultant pharmacist is broader than that of a pharmacist. A consultant pharmacist may order and evaluate laboratory testing in addition to the services provided by a pharmacist. For example, a consultant pharmacist can order and evaluate clinical and laboratory testing for a patient residing in a nursing home upon authorization by the medical director of the nursing home.[26] Additionally, a consultant pharmacist may order and evaluate clinical and laboratory testing for individuals under the care of a licensed home health agency, if authorized by a licensed physician, podiatrist, or dentist.[27]

***Pharmacist Collaborative Practice Agreements***

A collaborative practice agreement (CPA) is a formal agreement in which a licensed practitioner makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.[28] A CPA specifies what functions beyond the pharmacist's typical scope of practice can be delegated to the pharmacist

[23] Fla. Admin. Code R. 64B16-26.300(3)(c)(2019).
[24] *Id.* To act as a preceptor, a person must be a consultant of record at an institutional pharmacy, have a minimum of one year experience as a consultant pharmacist of record, and be licensed, in good standing, with the board. A preceptor may not supervise more than two applicants at the same time.
[25] *Id.*
[26] Section 465.0125(1), F.S.
[27] Section 465.0125(2), F.S. To qualify to order and evaluate such testing, the consultant pharmacist or doctor of pharmacy must complete 3 hours of board-approved training, related to laboratory and clinical testing.
[28] U.S. Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention, *Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Pharmacists*, (2013), *available at* https://www.cdc.gov/dhdsp/pubs/docs/translational_tools_pharmacists.pdf (last visited Feb. 7, 2020).

by the collaborating health care practitioner.[29] Common tasks include initiating, modifying, or discontinuing medication therapy and ordering and evaluating tests.[30]

As of May 2016, 48 states, including Florida, permit some type of collaborative practice between a pharmacist and a prescriber.[31] However, the laws and regulations of these states vary in areas such as the functions that may be authorized, the requirements for collaborative agreements, and the qualifications for participants.[32]

## III. Effect of Proposed Changes:

The bill amends s. 465.003, F.S., to expand the scope of the, "practice of the profession of pharmacy," to include:

- Ordering and evaluating any laboratory or clinical testing;
- Conducting patient assessments;
- Modifying, discontinuing, or administering medicinal drugs pursuant to s. 465.0125, F.S. by a consultant pharmacist; and
- Conducting "other pharmaceutical services," which includes reviewing and making recommendations regarding the patient's drug therapy and health care status with the patient's prescribing physician, podiatrist, or dentist regarding the patient's drug therapy and health care status.

The bill amends s. 465.0125, F.S., authorizing a consultant pharmacist to enter into a written CPA with a health care facility medical director, or a Florida-licensed allopathic physician, osteopathic physician, podiatric physician, or dentist, who is authorized to prescribe medication, to provide medication management services, which may include:

- Order and evaluate any laboratory or clinical tests to promote and evaluate patient health and wellness, and monitor drug therapy and treatment outcomes;
- Conduct patient assessments as appropriate to evaluate and monitor drug therapy;
- Modify, or discontinue medicinal drugs as outlined in the agreed upon patient-specific order or preapproved treatment protocol under the direction of a physician; and
- Administer medicinal drugs.

The bill defines a health care facility to expand the locations in which a consultant pharmacist services may be offered, to include:

- Ambulatory surgical center;
- Alcohol or chemical dependency treatment center;
- Inpatient hospice;
- Hospital;
- Ambulatory care center; or
- Nursing home or nursing home within a continuing care facility.

---

[29] U.S. Center for Disease Control and Prevention, *Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team*, (2017) *available at* https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf (last visited Feb. 7, 2020).
[30] *Supra* note 28.
[31] *Supra* note 29.
[32] *Id.*

The bill prohibits a consultant pharmacist from modifying or discontinuing a medication if the consultant pharmacist does not have a written collaborative practice agreement with the consultant pharmacist; and clarifies that a consultant pharmacist is not authorized to diagnose any disease or condition.

The consultant pharmacist must maintain all drug, patient care and quality assurance records as required by current law; and, with the collaborating practitioner, must maintain written collaborative practice agreements that must be available upon request or during any department inspection.

The Board previously established, by rule, the additional training required for licensure as a consultant pharmacist under its general rulemaking authority.[33] The bill gives the Board express authority to establish additional education requirements for licensure as a consultant pharmacist.

The bill provides an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[33] *Supra* note 21.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 1094 will require the department to incur non-recurring costs for rulemaking, which current resources are adequate to absorb.[34]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

The bill is unclear as to where the written CPAs will be kept, and who, the consultant pharmacist or the collaborating practitioner, will be responsible for making them "available upon from the department or upon inspection by the department."

The bill expands the locations where a consultant pharmacist may practice, some of which are not inspected by the department, but by the Agency for Health Care Administrative (ACHA). The bill does not require the consultant pharmacist or the collaborating practitioner to make the CPA available to the AHCA upon request or inspection.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 465.003 and 465.0125.

## IX. Additional Information:

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

**CS by Health Policy on February 11, 2020:**
The CS:

- Removes from the underlying bill's definition of the "practice of professional pharmacy" the ability to "initiate" medicinal drugs;
- Removes the ability of consultant pharmacists in the underlying bill to "initiate" medicinal drugs pursuant to a CPA with a physician, podiatrist, or dentist; and
- Requires the CPA be in writing.

B. Amendments:

None.

[34] Florida Department of Health fiscal analysis of SB 1094 (February 7, 2020)(on file with the Senate Appropriations Subcommittee on Health and Human Services).

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** February 14, 2020

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I respectfully request that **Senate Bill # 1094**, relating to Consultant Pharmacists, be placed on the:

☐ Committee agenda at your earliest possible convenience.

☒ Next committee agenda.

Senator Manny Diaz, Jr.
Florida Senate, District 36

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)

02/25/2020
*Meeting Date*

SB 1094
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Consultant Pharmacists

Name Joseph Salzverg ("Saul's-verg")

Job Title Attorney/Lobbyist

Address 301 S. Bronough St. #600
*Street*

TLH FL 32301
*City* *State* *Zip*

Phone (850) 577-9090

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Society of Health System Pharmacists

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

February 25, 2020
*Meeting Date*

CS/SB 1094
*Bill Number (if applicable)*

Topic CONSULTANT PHARMACIST

*Amendment Barcode (if applicable)*

Name Michael Jackson

Job Title Executive Vice President and CEO

Address 610 North Adams Street
*Street*

Phone (850) 222-2400

Tallahassee — *City* | Florida — *State* | 32301 — *Zip*

Email mjackson@pharmview.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 1094
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic _____

Name Jeff Scott

Job Title _____

Address 1130 Piedmont Dr. E.
*Street*
Tallahassee FL 32308
*City* *State* *Zip*

Phone 850 224 6996

Email jscott@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 1094
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Aimee Diaz Lyon

Job Title _____

Address 119 South Monroe Street #200
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone 850-205-9000

Email aimee.diazlyon@mhdlaw.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing the Florida Academy of Family Physicians (FAFP)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

**By** the Committee on Health Policy; and Senator Diaz

588-03469-20 20201094c1

A bill to be entitled

An act relating to consultant pharmacists; amending s. 465.003, F.S.; revising the definition of the term "practice of the profession of pharmacy"; amending s. 465.0125, F.S.; requiring a pharmacist to complete additional training to be licensed as a consultant pharmacist; authorizing a consultant pharmacist to perform specified services under certain conditions; prohibiting a consultant pharmacist from modifying or discontinuing medicinal drugs prescribed by a health care practitioner under certain conditions; revising the responsibilities of a consultant pharmacist; requiring a consultant pharmacist and a collaborating practitioner to maintain collaborative practice agreements; requiring collaborative practice agreements to be made available upon request from or upon inspection by the Department of Health; prohibiting a consultant pharmacist from diagnosing any disease or condition; defining the term "health care facility"; providing an effective date.

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

Section 1. Subsection (13) of section 465.003, Florida Statutes, is amended to read:

465.003 Definitions.—As used in this chapter, the term:

(13) "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting







588-03469-20 20201094c1

concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and conducting other pharmaceutical services. For purposes of this subsection, the term "other pharmaceutical services" means ~~the~~ monitoring ~~of~~ the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes reviewing, and making recommendations regarding, ~~review of~~ the patient's drug therapy and health care status in communication with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or a similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient~~, regarding the drug therapy~~. However, ~~nothing in~~ this subsection may not be interpreted to permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. The term "practice of the profession of pharmacy" also includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The practice of the profession of pharmacy also includes the administration of vaccines to adults pursuant to s. 465.189 and the preparation of prepackaged drug products

in facilities holding Class III institutional pharmacy permits. The term also includes ordering and evaluating any laboratory or clinical testing; conducting patient assessments; and modifying, discontinuing, or administering medicinal drugs pursuant to s. 465.0125 by a consultant pharmacist.

Section 2. Section 465.0125, Florida Statutes, is amended to read:

465.0125 Consultant pharmacist license; application, renewal, fees; responsibilities; rules.—

(1) The department shall issue or renew a consultant pharmacist license upon receipt of an initial or renewal application that ~~which~~ conforms to the requirements for consultant pharmacist initial licensure or renewal as adopted ~~promulgated~~ by the board by rule and a fee set by the board not to exceed $250. To be licensed as a consultant pharmacist, a pharmacist must complete additional training as required by the board.

(a) A consultant pharmacist may provide medication management services in a health care facility within the framework of a written collaborative practice agreement between the pharmacist and a health care facility medical director or a physician licensed under chapter 458 or chapter 459, a podiatric physician licensed under chapter 461, or a dentist licensed under chapter 466 who is authorized to prescribe medicinal drugs. A consultant pharmacist may provide medication management services, conduct patient assessments, and order and evaluate laboratory or clinical testing only for patients of the health care practitioner with whom the consultant pharmacist has a written collaborative practice agreement.





(b) A written collaborative practice agreement must outline the circumstances under which the consultant pharmacist may:

1. Order and evaluate any laboratory or clinical tests to promote and evaluate patient health and wellness, and monitor drug therapy and treatment outcomes.

2. Conduct patient assessments as appropriate to evaluate and monitor drug therapy.

3. Modify or discontinue medicinal drugs as outlined in the agreed-upon patient-specific order or preapproved treatment protocol under the direction of a physician. However, a consultant pharmacist may not modify or discontinue medicinal drugs prescribed by a health care practitioner who does not have a written collaborative practice agreement with the consultant pharmacist.

4. Administer medicinal drugs.

(c) A ~~The~~ consultant pharmacist shall maintain ~~be responsible for maintaining~~ all drug, patient care, and quality assurance records as required by law and, with the collaborating practitioner, shall maintain written collaborative practice agreements that must be available upon request from or upon inspection by the department.

(d) This subsection does not authorize a consultant pharmacist to diagnose any disease or condition.

(e) For purposes of this subsection, the term "health care facility" means an ambulatory surgical center or hospital licensed under chapter 395, an alcohol or chemical dependency treatment center licensed under chapter 397, an inpatient hospice licensed under part IV of chapter 400, a nursing home licensed under part II of chapter 400, an ambulatory care center

as defined in s. 408.07, or a nursing home component under chapter 400 within a continuing care facility licensed under chapter 651 ~~for establishing drug handling procedures for the safe handling and storage of drugs. The consultant pharmacist may also be responsible for ordering and evaluating any laboratory or clinical testing when, in the judgment of the consultant pharmacist, such activity is necessary for the proper performance of the consultant pharmacist's responsibilities. Such laboratory or clinical testing may be ordered only with regard to patients residing in a nursing home facility, and then only when authorized by the medical director of the nursing home facility. The consultant pharmacist must have completed such additional training and demonstrate such additional qualifications in the practice of institutional pharmacy as shall be required by the board in addition to licensure as a registered pharmacist~~.

(2) Notwithstanding ~~the provisions of~~ subsection (1), a consultant pharmacist or a doctor of pharmacy licensed in this state may also be responsible for ordering and evaluating any laboratory or clinical testing for persons under the care of a licensed home health agency when, in the judgment of the consultant pharmacist or doctor of pharmacy, such activity is necessary for the proper performance of his or her responsibilities and only when authorized by a practitioner licensed under chapter 458, chapter 459, chapter 461, or chapter 466. In order for the consultant pharmacist or doctor of pharmacy to qualify and accept this authority, he or she must receive 3 hours of continuing education relating to laboratory and clinical testing as established by the board.





(3) The board shall adopt ~~promulgate~~ rules necessary to implement and administer this section.

Section 3. This act shall take effect July 1, 2020.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1206 |
| INTRODUCER: | Health Policy Committee and Senator Harrell |
| SUBJECT: | Applied Behavior Analysis Services |
| DATE: | February 24, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Kibbey | Brown | HP | **Fav/CS** |
| 2. | Gerbrandt | Kidd | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1206 exempts a group practice that provides applied behavior analysis (ABA) services from licensure and regulation as a health care clinic.

The bill requires the Agency for Persons with Disabilities (APD) to recognize the certification of registered behavior technicians (RBTs) by a nonprofit corporation in the same manner that the APD is currently required to recognize the certification of behavior analysts.

The bill authorizes certified RBTs who practice under the supervision of a certified behavior analyst or a mental health professional licensed under chapter 490 or chapter 491, to assist and support that professional in providing ABA services in the K-12 classroom setting.

The bill has an insignificant impact on state expenditures, which can be absorbed within existing agency resources. The bill has an indeterminate negative fiscal impact on the AHCA due to a loss in revenue from exempting ABA group providers from health care clinic licensure.

The bill provides an effective date of July 1, 2020.

## II. Present Situation:

### Health Care Clinics

The Health Care Clinic Act (Act), ss. 400.990-400.995, F.S., was enacted in 2003 as part of the Florida Motor Vehicle insurance Affordability and Reform Act to address personal injury protection insurance exploitation.[1] To prevent significant harm to consumers the purpose of the Act is to strengthen regulation of health care clinics through licensure, and establishment and enforcement of basic standards for health care clinics. Regulation of health care clinics was transferred from the Department of Health (DOH) to the Agency for Health Care Administration (AHCA), to be funded by license application fees.[2]

To be licensed as a health care clinic, an entity must submit a completed application form to the AHCA and must:[3]

- Submit to a level-2 background screening for owners and certain employees and officers;
- Demonstrate its financial ability to operate;
- Pay the licensure application fee ($2,000 every 2 years);
- Provide evidence of incorporation or fictitious name;
- Provide proof of the applicant's legal right to occupy the property; and
- Provide proof of any required insurance.

Each health care clinic must appoint a medical or clinical director.[4] The medical director must be a physician licensed as an allopathic physician, an osteopathic physician, a chiropractic physician, or a podiatric physician.[5] If the clinic does not provide services pursuant to those physicians' respective practices acts, it may appoint a Florida-licensed health care practitioner to serve as a clinic director.[6]

Because ABA service providers are not licensed in Florida, an ABA practice licensed as a health care clinic would need to retain a state-licensed health care practitioner to serve as its medical or clinical director in order to comply with the Act.

The AHCA is responsible for licensing and regulating facilities that meet the definition of a health care clinic. A "health care clinic" is an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider.[7] Currently, there are fourteen exemptions from the definition of health care clinic and from the licensure requirements. Most of these exemptions are provided for entities that:[8]

- Are already regulated by the AHCA as a health care provider for licensure;

[1] Chapter 2003-411, Laws of Fla.
[2] *Id.* .
[3] *See* s. 400.991 ,F.S. and 59A-33.002, F.A.C.
[4] Section 400.9935(1), F.S.
[5] Section 400.9905(5), F.S.
[6] *Id.*
[7] Section 400.9905(4), F.S.
[8] Agency for Health Care Administration, *House Bill 575 Analysis* (November 13, 2019) (on file with the Senate Committee on Health Policy).

- Are federally-certified;
- Are otherwise regulated by the DOH or the Department of Children and Families or elsewhere in the Florida Statutes; or
- Have substantial financial commitment.

The AHCA licenses 2,454 health care clinics and 4,720 providers hold an active certificate of exemption.[9] An entity may apply for a certificate of an exemption, which costs $100 every two years.[10]

Mental health professionals licensed under ch. 490, F.S., (psychological services) or under ch. 491, F.S., (clinical, counseling, and psychotherapy services) who provide services within their scope of practice are granted such an exemption under s. 400.9905(4)(g), F.S., but there is no current exemption for persons or groups providing ABA services.

**Applied Behavior Analysis Services**

ABA is a therapeutic approach to dealing with behavioral disorders that is based on the science of learning and behavior.[11] The primary recipients of ABA services are individuals with autism spectrum disorder.[12] ABA seeks to reduce unwanted behavior patterns and to teach new, productive skills to help drive meaningful change.[13] Individuals participating in ABA strive to improve language capabilities and other communication skills, limit negative behavioral patterns, improve learning outcomes, and develop social skills.[14]

The AHCA covers behavior analysis services for children enrolled in Medicaid ages 0 through 20 with significant maladaptive behaviors, when medically necessary.[15] Before a child can receive ABA services, the child must be referred for a behavior assessment by his or her treating practitioner.[16]

Health insurers and health maintenance organizations are required to issue coverage for ABA services for individuals under 18 years of age, or individuals over 18 years of age who are in high school, who have been diagnosed as having a developmental disability at 8 years of age or younger.[17] ABA services must be provided by individuals certified as behavior analysts under s. 393.17, F.S., or licensed under chs. 490 or 491, F.S.[18]

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[9] *Id.*
[10] *Id.*
[11] TEACH Make a Difference, *What is Applied Behavior Analysis (ABA)?*, https://teach.com/online-ed/psychology-degrees/what-is-aba/ (last visited Feb 13, 2020).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] Agency for Health Care Administration, *Behavior Analysis Services Information*, available at: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/bhfu/BA_Services.shtml (last visited Feb. 13, 2020).
[16] *Id.*
[17] Sections 627.6686 and 641.31098, F.S.
[18] *Id.*

**ABA Service Providers and Certification**

There are three provider types of ABA services:[19]

- Board Certified Behavior Analyst (BCBAs) – These providers have either a masters or doctoral degree with a background in ABA.
- Board Certified Assistant Behavior Analysts (BCaBAs) – These providers have a bachelor's degree with a background in ABA.
- Registered Behavior Technicians (RBTs) – These providers have at least a high school diploma, have undergone 40 hours of training, and have passed an exam. RBTs can deliver ABA services under the supervision of a BCBA or a BCaBA.

The APD is required to recognize a non-profit corporation for the certification of behavior analysts. The non-profit corporation is required to:[20]

- Adhere to the national standards of boards that determine professional credentials; and
- Have a mission to meet professional credentialing needs identified by behavior analysts, state governments, and consumers of behavior analysis services.

Further, the certification procedure recognized by the APD must undergo regular psychometric review and validation, pursuant to a job analysis survey of the profession and standards established by content experts in the field.[21] The APD recognizes the certification awarded by the Behavior Analyst Certification Board, Inc.,[22] which certifies the three provider types and recently added a fourth provider type: the BCBA-D for board certified behavior analysists who hold doctoral degrees.[23]

The APD reports that there are 173 certified ABA service providers.[24] The APD website provides a directory to identify certified behavioral analysis service providers.[25]

## III. Effect of Proposed Changes:

**Section 1** amends s. 393.17, F.S., to authorize the APD to establish a certification process for RBTs and to require the APD to recognize the certification of RBTs awarded by a nonprofit corporation that meets criteria established in current law, such as adhering to the national standards of boards that determine professional credentials relating to ABA.

**Section 2** amends s. 400.9905(4), F.S., to exempt a group of certified behavior analysts or individuals licensed under chs. 490 or 491, F.S., and who provide applied behavior analysis services from health care clinic licensure. The AHCA is not able to distinguish behavioral analysis providers from other types of health care clinics, so the AHCA is unable to determine

[19] Behavior Analyst Certification Board https://www.bacb.com/ (last viewed Feb. 13, 2020).
[20] Section 393.17(2), F.S.
[21] *Id.*
[22] Rule 65G-4.0011, F.A.C.
[23] *Supra* note 19.
[24] *Supra* note 8.
[25] Agency for Persons with Disabilities, *Resource Directory*, available at: https://resourcedirectory.apd.myflorida.com/resourcedirectory/ (last visited Feb. 13, 2020).

how many behavior analysis providers are currently licensed as health care clinics.[26] The total number of providers affected by Section 2 of the bill is unknown.

**Section 3** amends s. 1003.572, F.S., to expand the definition of "private instructional personnel" for purposes of allowing such personnel to provide services in a K-12 classroom. The definition is expanded to include certified RBTs who practice under the supervision of a certified behavior analyst or a mental health professional licensed under chapter 490 or chapter 491, and who assist and support such a provider in providing ABA services.

**Sections 4-6** of the bill amend ss. 456.47, 627.6686, and 641.31098, F.S., to make conforming changes.

**Section 7** provides an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 1206 will have a positive fiscal impact on eligible ABA service providers who apply for a $100 certificate of exemption instead of a $2,000 health care clinic license.

[26] Supra note 8.

C. Government Sector Impact:

The bill has a significant positive fiscal impact on the AHCA due the exemption of certain ABA service providers from health care clinic licensure, which reduces workload within the AHCA's Division of Health Quality Assurance because the division will not have to license or survey exempted ABA service providers.

The bill has an indeterminate negative fiscal impact on the AHCA due to a loss in revenue from exempting ABA group providers from health care clinic licensure. However, the AHCA is not able to distinguish behavioral analysis providers from other types of health care clinics, and therefore, is unable to determine how many behavior analysis providers are currently licensed as health care clinics.[27]

Under the bill, the AHCA will need to update Rule 5G-1.060 of the Florida Administrative Code to remove a reference to behavior analysis groups in regard to health care clinic licensure. The AHCA will experience minor operational cost that can be absorbed within existing resources.[28]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 393.17, 400.9905, 456.47, 627.6686, 641.31098, and 1003.572.

## IX. Additional Information:

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

**CS by Health Policy on February 4, 2020:**
The CS:

- Requires the APD to recognize the certification of registered behavior technicians (RBTs) by a nonprofit corporation in the same manner that the APD is currently required to recognize the certification of behavior analysts.
- Reverts to the current law and removes a provision on lines 44-45 of the underlying bill that would require the Department of Education (DOE) to approve a nonprofit credentialing entity to certify behavior analysts. The CS keeps the certification of behavior analysts under s. 393.17, F.S., which currently requires the APD to recognize a corporation for the certification of behavior analysts.

[27] Supra note 8.
[28] *Supra* note 8.

- Replaces the word "paraprofessionals" on line 48 of the underlying bill with RBTs certified under s. 393.17, F.S., to narrow the scope of who may assist a behavior analyst in providing ABA services in K-12 classrooms and to ensure that those providers are qualified.
- Makes conforming changes.

B. Amendments:

None.

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

**JOINT COMMITTEE:**
Joint Committee on Public Counsel Oversight

**SENATOR GAYLE HARRELL**
25th District

February 12, 2020

Senator Aaron Bean
405 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Bean,

I respectfully request that **SB 1206 – Applied Behavior Analysis** be placed on the next available agenda for the Appropriations Subcommittee on Health and Human Services Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

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

**BILL GALVANO**
**President of the Senate**

**DAVID SIMMONS**
**President Pro Tempore**

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

SB 1206
*Bill Number (if applicable)*

Topic Applied Behavior Analysis Services

*Amendment Barcode (if applicable)*

Name Dr. Steve Coleman

Job Title Public Policy Director

Address 3116 Capital Circle, NE.
*Street*

Tallahassee FL 32308
*City* *State* *Zip*

Phone 904-635-7155

Email steve_coleman@fabaworld.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Association for Behavior Analysis

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/2020
*Meeting Date*

SB 1206
*Bill Number (if applicable)*

Topic Applied Behavior Analysis Services

*Amendment Barcode (if applicable)*

Name Marta T. "Tiki" Fiol

Job Title BCBA

Address 1658 Davis Dr.
*Street*

Merritt Island FL 32952
*City* *State* *Zip*

Phone 321-961-7831

Email tikifiol@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Association for Behavior Analysis

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-2020
*Meeting Date*

SB 1206
*Bill Number (if applicable)*

Topic SB 1206 ABA

*Amendment Barcode (if applicable)*

Name Carolyn O'Connell

Job Title Owner O'Connell Behavioral Services

Address 5432 Rattlesnake Hammock Rd
*Street*

Phone 239-316-7656

Naples FL 34113
*City* *State* *Zip*

Email Coconnell@oconnellbehavior.com

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

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

Representing

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

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

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-2020
*Meeting Date*

SB1206
*Bill Number (if applicable)*

Topic Applied Behavior Analysis

*Amendment Barcode (if applicable)*

Name Marucci (Ma-ru-chi) Guzman

Job Title President / Co-Founder

Address 3271 S. Chickasaw Trail
*Street*

Phone 407 968 0062

Orlando FL 32829
*City* *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing ABA Providers Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3-25-2020
*Meeting Date*

SB 1206
*Bill Number (if applicable)*

Topic Applied Behavior Analysis

*Amendment Barcode (if applicable)*

Name Marytza Sanz

Job Title President/CEO

Address 9219 Everwood St
*Street*

Phone 407 925 4544

Orlando FL 32825
*City* *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Santiago & Friends | Family Center for Autism

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

**By** the Committee on Health Policy; and Senator Harrell

588-03101-20 20201206c1

A bill to be entitled

An act relating to applied behavior analysis services; amending s. 393.17, F.S.; authorizing the Agency for Persons with Disabilities to establish a certification process for registered behavior technicians; requiring the agency to recognize the certification of registered behavior technicians awarded by a nonprofit corporation that meets specified requirements; amending s. 400.9905, F.S.; providing an exemption from licensure requirements for certain individuals who are employed or under contract with certain entities providing applied behavior analysis services; amending s. 1003.572, F.S.; revising the definition of the term "private instructional personnel" to include certain registered behavior technicians; amending ss. 456.47, 627.6686, and 641.31098, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 393.17, Florida Statutes, is amended to read:

393.17 Behavioral programs; certification of behavior analysts and registered behavior technicians.—

(1) The agency may establish a certification process for behavior analysts and registered behavior technicians in order to ensure that only qualified employees and service providers provide behavioral analysis services to clients. The procedures







588-03101-20 20201206c1

must be established by rule and, for behavior analysts, must include criteria for scope of practice, qualifications for certification, including training and testing requirements, continuing education requirements for ongoing certification, and standards of performance. The procedures must also include decertification procedures that may be used to determine whether an individual continues to meet the qualifications for certification or the professional performance standards and, if not, the procedures necessary to decertify an employee or service provider.

(2) The agency shall recognize the certification of behavior analysts and registered behavior technicians awarded by a nonprofit corporation that adheres to the national standards of boards that determine professional credentials and whose mission is to meet professional credentialing needs identified by behavior analysts, state governments, and consumers of behavior analysis services. The certification procedure recognized by the agency must undergo regular psychometric review and validation, pursuant to a job analysis survey of the profession and standards established by content experts in the field.

Section 2. Paragraph (o) is added to subsection (4) of section 400.9905, Florida Statutes, to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not

apply to:

(o) A group of individuals certified as behavior analysts under s. 393.17, or licensed under chapter 490 or chapter 491, and who are employed by or under contract with a group practice, a billing provider, or an agency that provides applied behavior analysis services as defined in ss. 627.6686 and 641.31098.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 3. Present paragraphs (b) through (f) of subsection (1) of section 1003.572, Florida Statutes, are redesignated as paragraphs (c) through (g), respectively, a new paragraph (b) is added to that subsection, and paragraph (a) of that subsection is republished, to read:

1003.572 Collaboration of public and private instructional personnel.—

(1) As used in this section, the term "private instructional personnel" means:

(a) Individuals certified under s. 393.17 or licensed under chapter 490 or chapter 491 for applied behavior analysis services as defined in ss. 627.6686 and 641.31098.

(b) Registered behavior technicians certified under s. 393.17 who practice under the supervision of a professional authorized under paragraph (a) and who assist and support such professional in providing applied behavior analysis services.

Section 4. Paragraph (b) of subsection (1) of section 456.47, Florida Statutes, is amended to read:





456.47 Use of telehealth to provide services.—

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

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17 as a behavior analyst; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multistate health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

Section 5. Paragraph (b) of subsection (3) of section 627.6686, Florida Statutes, is amended to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(3) A health insurance plan issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(b) Treatment of autism spectrum disorder and Down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Applied behavior analysis services shall be provided by an individual certified as a behavior analyst pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

Section 6. Paragraph (b) of subsection (3) of section 641.31098, Florida Statutes, is amended to read:

641.31098 Coverage for individuals with developmental disabilities.—

(3) A health maintenance contract issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(b) Treatment of autism spectrum disorder and Down syndrome, through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services. Applied behavior analysis services shall be provided by an individual certified as a behavior analyst pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

Section 7. This act shall take effect July 1, 2020.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1296 |
| INTRODUCER: | Health Policy Committee; and Senators Berman and Rodriguez |
| SUBJECT: | Health Access Dental Licenses |
| DATE: | February 24, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Rossitto-Van Winkle | Brown | HP | **Fav/CS** |
| 2. | Howard | Kidd | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 1296 revives, reenacts, and amends ss. 466.0067, 466.00671, and revives and reenacts 466.00672, F.S., relating to health access dental licenses, notwithstanding their repeal on January 1, 2020. This gives the Department of Health (department) and the Board of Dentistry the statutory authority to resume issuing and renewing such licenses.

The bill has an insignificant fiscal impact on the department that can be absorbed within existing resources.

The bill takes effect upon becoming a law.

## II. Present Situation:

### Dentistry

Section 466.004, F.S., establishes the Board of Dentistry (BOD) within the Department of Health (department) to regulate the practice of dentistry. The requirements for dental licensure by examination are found in s. 466.006, F.S. A person desiring to be licensed as a dentist must apply to the department to take the examinations. To take the examination, an applicant must be 18 years of age or older and be:

- A graduate from a dental school accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA), or any other dental accrediting entity recognized by the U.S. Department of Education (DOE); or
- A dental student in the final year of a program at such an ADA CODA accredited dental school who has completed all the coursework necessary to prepare the student to perform the clinical and diagnostic procedures required to pass the examinations.

Dental school graduates from a school not accredited by the ADA CODA, a U.S. DOE-recognized dental accrediting entity, or approved by the BOD, desiring to take the Florida dental licensure examinations, are not entitled to take the examinations until the applicant:

- Demonstrates completion of a program of study defined by BOD rule, at an accredited American dental school and receipt of a D.D.S. or D.M.D. from the school; or
- Submits proof of successful completion of at least two consecutive years at a full-time supplemental general dentistry program accredited by the ADA CODA.[1]

The Legislature has authorized the BOD to use the American Dental Licensing Examination (ADLEX), developed by the American Board of Dental Examiners, Inc., in lieu of an independent state-developed practical or clinical examination.

***Health Access Dental Licenses***

In 2008, the Legislature established the health access dental license[2] in order to attract out-of-state dentists to practice in Florida's underserved health access settings.[3] On January 1, 2020, ss. 466.0067 through 466.00673, F.S., were repealed when the Legislature failed to reenact those statutes, as provided under s. 466.00673, F.S. However, health access dental licenses issued before January 1, 2020, are not affected by the repeal and remain valid under the provisions of the former ss. 466.0067-466.00673, F.S.[4]

With a health access dental license, a dentist actively licensed and in good standing in another state, the District of Columbia, or a U.S. territory, is authorized to practice dentistry in Florida in a health access setting if the dentist:

- Submits proof he or she graduated from a dental school accredited by the Commission on Dental Accreditation of the ADA or its successor agency;

[1] Florida Dept. of Health, *Senate Bill 188 Analysis* (2019) (on file with the Senate Committee on Health Policy), p. 3. According to the DOH, it is unclear whether the two years of a full time supplemental general dentistry program includes specialty or advanced education programs.
[2] See ss. 466.0067, 466.00671, 466.00672, and 466.00673, F.S.
[3] A "health access setting" is defined in s. 466.003(14), F.S., as a program or institution of the Department of Children and Families, the Department of Health, or the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center (FQHC) or FQHC look-alike as defined by federal law, a school-based prevention program, or a clinic operated by an accredited college of dentistry or an accredited dental hygiene program in this state if such community service programs and institutions immediately report to the Board of Dentistry practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such settings.
[4] Section 466.00673, F.S., prior to January 1, 2020, provided that "Effective January 1, 2020, ss. 466.0067-466.00673, F.S., are repealed unless reenacted by the Legislature. Any health access dental license issued before January 1, 2020, shall remain valid according to ss. 466.0067-466.00673, F.S., without effect from repeal."

- Submits proof he or she has successfully completed parts I and II of the National Board of Dental Examiners (NBDE) examination and a state or regional clinical dental licensing examination that the BOD has determined effectively measures the applicant's ability to practice safely;
- Submits ADLEX examination scores mailed to the BOD directly from the American Dental Association;
- Submits a final official transcript from a dental school sent to the BOD by the registrar's office;
- Submits a certification of licensure from each state in which he or she currently holds or has held a dental or dental hygiene license;
- Submits proof of training in cardiopulmonary resuscitation (CPR) at the basic support level;
- Files a BOD-approved application and pays the applicable fees;
- Has not been convicted of, nor pled *nolo contendere* to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Currently holds a valid, active dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another state, the District of Columbia, or a U.S. territory;
- Has never had a license revoked from another state, the District of Columbia, or a U.S. territory;
- Has never failed an exam under s. 466.006, F.S., unless the applicant was reexamined and received a license to practice in Florida;
- Has not been reported to the NBDE, unless the applicant successfully appealed to have his or her name removed from the data bank;
- Submits proof that he or she has been engaged in the active, clinical practice of dentistry and has provided direct patient care for five years immediately preceding the date of application, or proof of continuous clinical practice, and has provided direct patient care since graduation if the applicant graduated less than five years from his or her application date;
- Submits documentation that she or he has completed, or will complete prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006, F.S., for the last full reporting biennium before applying for a health access dental license;[5] and
- Successfully completes the examination covering the laws and rules of the practice of dentistry in this state.[6, 7]

A health access dental license is subject to biennial renewal. The BOD will renew a health access dental license if the applicant:

- Submits a renewal application and has paid a renewal fee;
- Submits documentation, as approved by the board, from the employer in the health access setting that the licensee has at all times pertinent remained an employee;
- Has not been convicted of, nor pled *nolo contendere* to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

[5] *See* ch. 64B5-12.013, Fla. Admin. Code R. (2019), for continuing education requirements.
[6] Section 466.006(4)(a), F.S.
[7] Department of Health, Board of Dentistry, *Health Access Dentist*, available at https://floridasdentistry.gov/licensing/health-access-dentist/ (last visited Jan. 8, 2020).

- Has not failed the examination specified in s. 466.006, F.S., since initially receiving a health access dental license or since the last renewal; and
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank.

The BOD may undertake measures to independently verify the health access dental licensee's ongoing employment status in the health access setting.

The BOD may revoke a health access dental license if the licensee is terminated from employment in the health access setting or practices outside of the health access setting, fails the Florida dental licensure examination, or is found by the BOD to have committed a violation of ch. 466, F.S., (the Dental Practice Act), other than a violation that is a citation offense or a minor violation.

Currently, the department has issued 60 health access dental licenses. Of those, 39 are in-state active, one is in-state delinquent, 11 are out-of-state active, two are out-of-state delinquent, and seven are retired.[8] As of January 1, 2020, the department is no longer authorized to issue initial health access dental licenses. Current health access dental licenses expire at midnight EST, February 28, 2020. The department is renewing current health access dental licenses and taking requests to reactivate such a license in inactive or retired status with the payment of additional fees and proof of compliance with specific continuing education requirements.[9]

## III. Effect of Proposed Changes:

The bill revives, reenacts, and amends ss. 466.0067, 466.00671, and revives and reenacts 466.00672, F.S., notwithstanding the January 1, 2020, repeal of those sections. The bill's amendments to those sections are for the purpose of grammatical corrections only.

The bill takes effect upon becoming a law.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

None.

[8] Florida Dept. of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan FY 2018-2019*, p. 13, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/index.html (last visited Jan. 8, 2020). "In-State Active" means the licensed practitioner has a Florida mailing address and is authorized to practice. "In-State Delinquent" means the licensed practitioner has a Florida mailing address and is not authorized to practice in the state because of failure to renew the license by the expiration date. "Out-of-State Active" means the licensed practitioner has an out-of-state mailing address and is authorized to practice. "Out-of-State Inactive" means the licensed practitioner has an out-of-state mailing address and is not authorized to practice. "Retired" means the licensed practitioner is not authorized to practice. The practitioner is not obligated to update licensure data. Section 456.036, F.S.

[9] Florida Dept. of Health, Board of Dentistry, *Health Access Dentist*, available at https://floridasdentistry.gov/renewals/health-access-dentist/ (last visited Jan. 8, 2020).

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 1296 would require the department to incur non-recurring costs for rulemaking that can be absorbed within existing resources. The department will have a minimal reduction in workload, costs, and revenues associated with the interruption period in issuing health access dental licenses.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill revives, reenacts, and amends the following sections of the Florida Statutes: 466.0067, and 466.00671 and revives and reenacts 466.00672, F.S.

## IX. Additional Information:

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

**CS by the Health Policy Committee on January 14, 2020:**
The CS changes the effective date of the bill from July 1, 2020, to upon becoming a law.

B. Amendments:

None.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

1296
*Bill Number (if applicable)*

Topic Health Access Dental Licenses

*Amendment Barcode (if applicable)*

Name Eric Stern

Job Title Legislative Committee Member

Address 1747 Orlando Central Pkwy
*Street*

Phone 800-373-5782

Orlando FL 32809
*City* *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida PTA

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 1296
*Bill Number (if applicable)*

Topic Health Access Dental License

*Amendment Barcode (if applicable)*

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Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

**By** the Committee on Health Policy; and Senator Berman

588-02263-20 20201296c1

A bill to be entitled

An act relating to health access dental licenses; reviving, reenacting, and amending s. 466.0067, F.S., relating to the application for a health access dental license; reviving, reenacting, and amending s. 466.00671, F.S., relating to the renewal of such license; reviving and reenacting s. 466.00672, F.S., relating to the revocation of such license; providing an effective date.

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

Section 1. Notwithstanding the January 1, 2020, repeal of section 466.0067, Florida Statutes, that section is revived, reenacted, and amended to read:

466.0067 Application for health access dental license.—The Legislature finds that there is an important state interest in attracting dentists to practice in underserved health access settings in this state and further, that allowing out-of-state dentists who meet certain criteria to practice in health access settings without the supervision of a dentist licensed in this state is substantially related to achieving this important state interest. Therefore, notwithstanding the requirements of s. 466.006, the board shall grant a health access dental license to practice dentistry in this state in health access settings as defined in s. 466.003 to an applicant who ~~that~~:

(1) Files an appropriate application approved by the board;

(2) Pays an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure



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



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fee. The fees specified in this subsection may not differ from an applicant seeking licensure pursuant to s. 466.006;

(3) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(4) Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;

(5) Submits documentation that she or he has completed, or will obtain before ~~prior to~~ licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006 for the last full reporting biennium before applying for a health access dental license;

(6) Submits proof of her or his successful completion of parts I and II of the dental examination by the National Board of Dental Examiners and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;

(7) Currently holds a valid, active~~,~~ dental license in good standing from another of the United States, the District of Columbia, or a United States territory which has not been revoked, suspended, restricted, or otherwise disciplined ~~from another of the United States, the District of Columbia, or a United States territory~~;

(8) Has never had a license revoked from another of the United States, the District of Columbia, or a United States territory;

(9) Has never failed the examination specified in s. 466.006, unless the applicant was reexamined pursuant to s.



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

466.006 and received a license to practice dentistry in this state;

(10) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank;

(11) Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and

(12) Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a).

Section 2. Notwithstanding the January 1, 2020, repeal of section 466.00671, Florida Statutes, that section is revived, reenacted, and amended to read:

466.00671 Renewal of the health access dental license.—

(1) A health access dental licensee shall apply for renewal each biennium. At the time of renewal, the licensee shall sign a statement that she or he has complied with all continuing education requirements of an active dentist licensee. The board shall renew a health access dental license for an applicant who ~~that~~:

(a) Submits documentation, as approved by the board, from the employer in the health access setting that the licensee has at all times pertinent remained an employee;

(b) Has not been convicted of or pled nolo contendere to,





regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(c) Has paid a renewal fee set by the board. The fee specified herein may not differ from the renewal fee adopted by the board pursuant to s. 466.013. The department may provide payment for these fees through the dentist's salary, benefits, or other department funds;

(d) Has not failed the examination specified in s. 466.006 since initially receiving a health access dental license or since the last renewal; and

(e) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank.

(2) The board may undertake measures to independently verify the health access dental licensee's ongoing employment status in the health access setting.

Section 3. Notwithstanding the January 1, 2020, repeal of section 466.00672, Florida Statutes, that section is revived and reenacted to read:

466.00672 Revocation of health access dental license.—

(1) The board shall revoke a health access dental license upon:

(a) The licensee's termination from employment from a qualifying health access setting;

(b) Final agency action determining that the licensee has violated any provision of s. 466.027 or s. 466.028, other than infractions constituting citation offenses or minor violations; or

(c) Failure of the Florida dental licensure examination.

(2) Failure of an individual licensed pursuant to s. 466.0067 to limit the practice of dentistry to health access settings as defined in s. 466.003 constitutes the unlicensed practice of dentistry.

Section 4. This act shall take effect upon becoming a law.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 1338 (599864) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Banking and Insurance Committee; and Senators Wright, Harrell, Rodriguez, and Perry |
| SUBJECT: | Prescription Drug Coverage |
| DATE: | February 26, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Johnson | Knudson | BI | **Fav/CS** |
| 2. | Gerbrandt | Kidd | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Technical Changes

## I. Summary:


PCS/CS/SB 1338 revises provisions of the Florida Insurance Code (code) relating to the transparency and oversight of pharmacy benefit managers (PBM) by the Office of Insurance Regulation (OIR). Specifically, the bill:

- Authorizes the OIR to examine PBMs to determine compliance with the provisions of the code;
- Requires insurers or Health Maintenance Organizations (HMO), and entities acting on their behalf, including a PBM, to comply with the pharmacy audit provisions;
- Provides that a pharmacy may appeal certain audit findings;
- Clarifies that an insurer or HMO remains responsible for any violations of the pharmacy audit requirements and the prompt pay law by a PBM acting on its behalf;
- Requires health insurers, HMOs, or pharmacy benefit managers on behalf of health insurers and HMOs to annually report to the OIR regarding rebates and other information;
- Authorizes the OIR to review an insurer's or HMOs contract with a PBM and to order the cancellation of the contract under certain conditions; and

The bill may have a significant negative fiscal impact on the OIR. See Section V.

The bill takes effect on July 1, 2020.

## II. Present Situation:

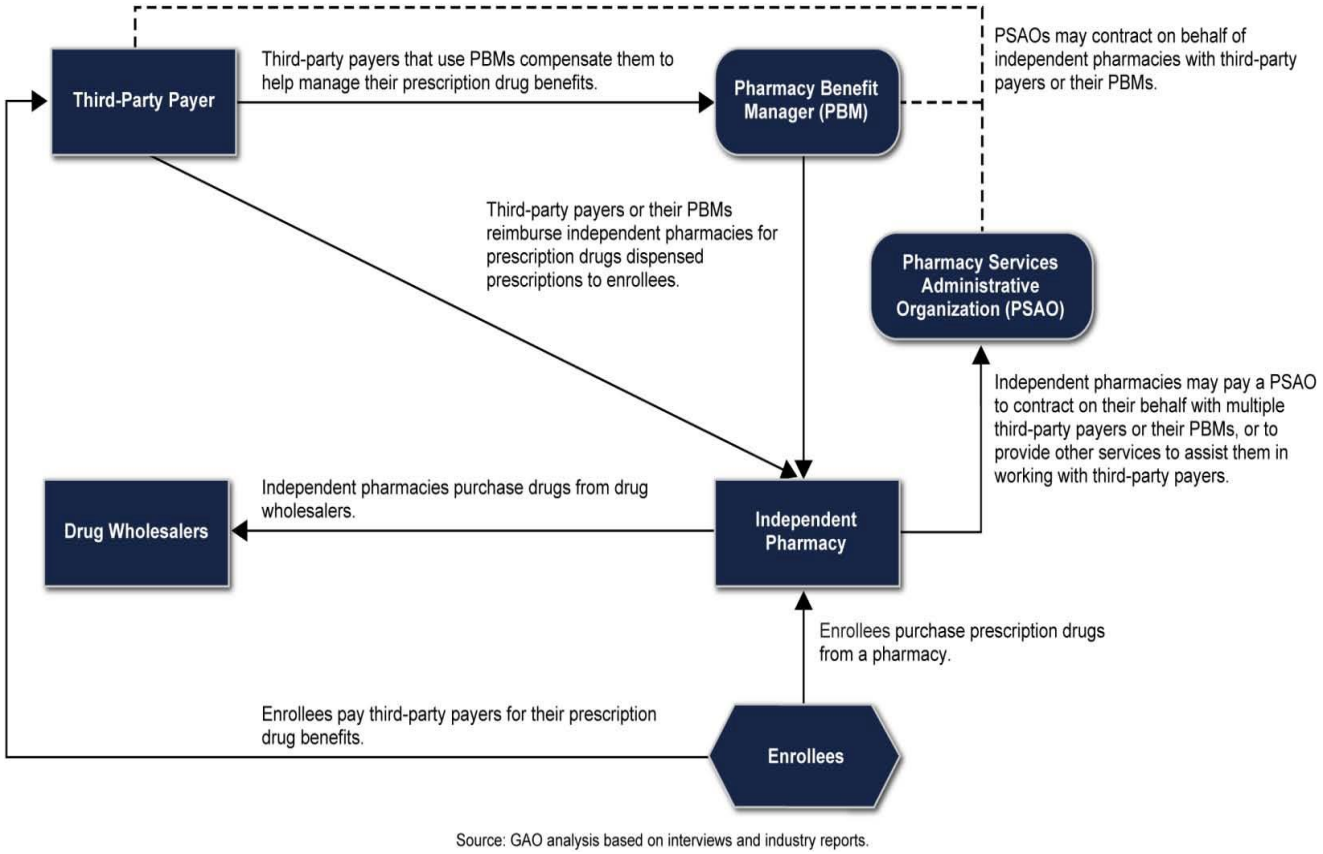
In 2019, private health insurance spending is expected to increase by 3.3 percent.[1] This trend is the net effect of faster spending growth in many services such as physician and clinical services and prescription drugs. In 2019, prescription drug spending growth was projected to increase by 4.6 percent, due to faster utilization growth from both existing and new drugs, as well as a modest increase in drug price growth. For the remainder of the projection period, 2020-2027, prescription drug spending is expected to grow by 6.1 percent per year on average, influenced by higher use anticipated from new drugs and efforts by employers and insurers that encourage patients with chronic conditions to treat their disease.[2]

### The Drug Supply Chain

The affordability of prescription drugs has gained attention at the state and federal level. In recent years, PBMs and drug manufacturers have come under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Many stakeholders (drug manufacturers, drug wholesalers, pharmacy services administrative organizations, pharmacy benefit managers, health plans, employers, and consumers) are involved with, and pay different prices for, prescription drugs as they move from the drug manufacturer to the insured.

In general, manufacturers develop and sell their drugs to wholesalers, and wholesalers then sell the drugs to pharmacies. With limited time and resources, some independent pharmacies may need assistance in interacting with these entities, particularly with third-party payers that include large private and public health plans. Many use a pharmacy services administrative organization (PSAO) to interact on their behalf. The PSAOs develop networks of pharmacies by signing contractual agreements with each pharmacy that authorizes them to negotiate with third-party payers on the pharmacy's behalf. Drug wholesalers and independent pharmacy cooperatives owned the majority of PSAOs in operation in 2011 or 2012.[3] Health insurers, HMOs, or employers may contract with PBMs to manage their prescription drug benefits.. The interaction among key entities involved in the distribution and payment of prescription drugs is depicted below:[4]

[1] *See* National Health Expenditure Projections 2018-2027, Forecast Summary, The Office of the Actuary in the Centers for Medicare & Medicaid Services, *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf* (last viewed Nov. 20, 2019).
[2] *Id.*
[3] General Accounting Office, *The Number, Role, and Ownership of Pharmacy Services Administrative Organizations* (GAO-13-176) (Feb 28, 2013) at https://www.gao.gov/products/GAO-13-176 (last viewed Jan. 20, 2020).
[4] *Id.*




Source: GAO analysis based on interviews and industry reports.

**A Study of 15 Large Employer Plans**[5]

In response to concerns about rising drug costs, a recent study evaluated drug utilization from plan sponsors to estimate savings from reducing the use of high cost, low-value drugs and described some of the cost concerns and challenges relating to the drug supply chain, as follows:

> PBMs negotiate with pharmaceutical manufacturers for price discounts, which are typically paid as rebates based on sales volumes driven by formulary placement. Rebates can reduce the final net price to the plan sponsor and may be passed on to patients. However, in exchange for low administration fees, plan sponsors allow PBMs to keep a portion of the negotiated rebates and other fees. Contracts between PBMs and plan sponsors contain rebate guarantees, perpetuating the demand for high-rebate drugs by encouraging PBMs to maximize rebate revenue, giving preference to some drugs over others on formularies based on rebate revenue rather than their value and final cost to the patient or plan sponsor. Additionally, PBMs earn revenue from "spread" pricing, which is the difference between what PBMs pay pharmacies on behalf of plan sponsors and what PBMs are reimbursed by the plan sponsor. This also encourages PBMs to prioritize higher-cost drugs to allow for a larger spread.

[5] Vela, Lauren, *Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans* (Aug. 2019) the Commonwealth Fund at https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/reducing-wasteful-spending-employers-pharmacy-benefit-plans (last viewed Feb. 12, 2020).

The report[6] further describes additional factors, which may increase costs for employers and insureds:

> …plan sponsors often allow broad formularies that include wasteful drugs because they are concerned that employees will be disappointed if their prescribed drugs are not covered. Doctors prescribe these drugs because they are often unaware of drug costs. Pharmaceutical manufacturers contribute to these patterns by promoting their products through "detailers" — pharmaceutical salespeople calling on doctors — when less costly alternatives may be clinically appropriate for patients. Plan sponsors have addressed the resulting high spending by increasing patient cost-sharing on lower-value drugs. Manufacturers counteract cost-sharing and formulary management tools by flooding the market with copayment coupons that undermine the benefit structure put in place by plan sponsors.

**Pharmacy Benefit Managers**

Many public and private employers and health plans contract with PBMs to help manage prescription drug costs. PBMs negotiate with retail pharmacies to obtain various discounts on prescription drugs. PBMs also offer the following services:

- Pharmacy claims processing;
- Mail-order pharmacy services;
- Drug formulary development and management; [7]
- Rebate negotiations with drug manufacturers;
- Pharmacy network development and management;
- Prospective and retrospective drug utilization reviews;
- Generic drug substitutions; and
- Disease management.[8]

A recent report found that PBMs passed through 78 percent of manufacturer rebates to health plans in 2012 and 91 percent in 2016.[9] For the same period, the report noted that manufacturer rebates grew from $39.7 billion to $89.5 billion, and played a growing role in partially offsetting increases in list prices, which the study noted have risen more quickly than overall retail prescription drug spending.[10]

In 2018, three companies processed about 75 percent of all equivalent prescription claims: CVS Health (including Caremark and Aetna), Express Scripts, and the OptumRx business of

[6] *Id.*
[7] A list of drugs that a health plan uses to make reimbursement decisions.
[8] Office of Program Policy Analysis and Government Accountability, Florida Legislature, *Legislature Could Consider Options to Address Pharmacy Benefit Manager Business Practices,* Report No. 07-08 (Feb. 2007).
[9] Reynolds, Ian, et. al., *The Prescription Drug Landscape, Explored* (Mar. 2019). The Pew Charitable Trusts.
[10] *Id.* There were 123 survey responses comprised of 114 individuals from commercial, managed Medicaid, and Medicare Part D health plans and 9 from PBMs.

UnitedHealth. The top six PBMs handled more than 95 percent of the total U.S. equivalent prescription claims managed.[11] The top six PBMs were:

- CVS Health (Caremark)/Aetna, 30 percent
- Express Scripts, 23 percent
- OptumRx (UnitedHealth), 23 percent
- Humana Pharmacy Solutions, 7 percent
- Medimpact Healthcare Systems, 6 percent
- Prime Therapeutics, 6 percent

***Reimbursement of Pharmacies by PBMs***

Generally, a contract between a PBM and a health plan sponsor or employer specifies the amount a plan or employer will pay a PBM for brand name and generic drugs. These prices are typically set as a discount off the average wholesale price for brand-name drugs and at a maximum allowable cost (MAC) for generic drugs (and sometimes brand drugs that have generic versions), plus a dispensing fee. The MAC represents the upper limit price that a plan will pay or reimburse for generic drugs and sometimes brand drugs that have generic versions available (multisource brands). A MAC pricing list creates a standard reimbursement amount for identical products.

A MAC pricing list is a common cost management tool that is developed from a proprietary survey of wholesale prices existing in the marketplace, taking into account market share, inventory, reasonable profit margins, and other factors. One of the purposes of the MAC pricing list is to ensure that the pharmacy or their buying groups are motivated to seek and purchase generic drugs at the lowest price in the marketplace. If a pharmacy procures a higher-priced product, the pharmacy may not make as much profit or in some instances may lose money on that specific purchase. If a pharmacy purchases generic drugs at a more favorable price, they will be more likely to make a profit.

**Retail Pharmacies**

Independent pharmacies[12] are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. Nationwide, the number of independent pharmacies in the United States continues to decline. In 2010, there were 23,106 independent pharmacies; by 2017, that number had dropped to 21,909.[13] Another report[14] noted that the number of independent retail pharmacies in Florida increased 32.4 percent from 2010 to 2019. During that same period, the number of independent retail pharmacists peaked in 2017 at 1,735, and declined to 1,541 in 2019.[15]

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[11] Drug Channels, CVS, Express Scripts, and the Evolution of the PBM Business Model (May 29, 2019) at https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html (last viewed Jan. 10, 2020).
[12] One definition of an independent provides that a pharmacy is considered independent if the total store count is fewer than four stores. *See* https://www.pharmacist.com/sites/default/files/files/Profile_16_Independent_SDS_FINAL_090307.pdf (last viewed Jan. 20, 2020).
[13] Arnold, Karen, *Independent Pharmacies: Not Dead Yet*, (Jan. 12, 2019, vol. 163, issue 1) Drug Topics, Voice of the Pharmacist.
[14] Quest Analytics analysis of NCPDP Pharmacy Count Data, 2019. Provided by PCMA. On file with Banking and Insurance Committee.
[15] *Id.*

The decision of employers, HMOs, or insurers to contract with PBMs may shift business away from smaller retail pharmacies that are also known as independent pharmacies. Historically, independent pharmacies were important health care providers in their communities and their pharmacists had long-term relationships with their patients.[16] However, many independent pharmacies have closed in recent years because of the competition resulting from the proliferation of large, chain retail pharmacies[17] that can negotiate with PBMs at deeply discounted reimbursement levels based on large volume sales. In 2018, further innovation and competition in the marketplace occurred with Amazon acquiring PillPack, a mail-order pharmacy, which has pharmacy licenses in all 50 states.[18] One report noted that Amazon has begun the process of undercutting prices of over the counter medications. [19] Further, some Amazon prices are 20 percent lower than brand medications sold at Walgreens and CVS.[20]

***Oversight of PBMs***

Current law requires PBMs to register with the OIR and requires contracts with PBMs to contain certain provisions.[21] However, the OIR does not have enforcement authority over PBMs to ensure compliance with the required contractual provisions, such as being able to revoke or suspend a PBM's registration or fine the PBM. Therefore, when the OIR addresses any statutory violations by a PBM, the OIR looks to the insurer or HMO, which contracts with the PBM to fulfill its obligations under the insurance code to resolve the situation.[22]

**Registration**. The registration process requires an applicant to remit a nonrefundable fee not to exceed $500, a copy of certain corporate documents, and a completed registration form. Registration and registration renewal certificates are valid for 2 years and are nontransferable.[23] Registrants must report any change in the registration information within 60 days of the change to the OIR.

**Contract Provisions.** Current law mandates that contracts between health insurers or HMOs and PBMs contain provisions requiring a PBM to:[24]

- Update the maximum allowable cost (MAC) pricing information at least once every 7 calendar days;
- Maintain a process that will eliminate drugs from the MAC lists or modify drug prices in a timely manner to remain consistent with changes in pricing data;

[16] Independent pharmacies are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. See http://www.gao.gov/assets/660/651631.pdf (last viewed Jan. 19, 2020).
[17] Such as Walmart, CVS, Walgreens, Publix or Kroger.
[18] Garcia, Ahiz, *Amazon rolls out "Amazon Pharmacy" branding to PillPack*, CNN Business (Nov. 15, 2019) at *https://www.cnn.com/2019/11/15/tech/amazon-pharmacy-pillpack/index.html* (last viewed Jan. 22, 2020).
[19] Cauley, Michael, *Amazon: What Will be its Impact on Community Pharmacy?* https://www.managedhealthcareconnect.com/blog/amazon-what-will-be-its-impact-community-pharmacy
[20] *Id.*
[21] *See* section 624.490, F.S., for information on registration of pharmacy benefit managers, and s. 627.64741, F.S., for information on pharmacy benefit manager contract requirements.
[22] Office of Insurance Regulation, *2020 Legislative Analysis of SB 1338* (Jan. 2, 2020).
[23] *Id.*
[24] Sections 627.64741, 627.6572, and 641.314, F.S.

- Refrain from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244, F.S.
- Refrain from requiring an insured to pay for a prescription drug at the point of sale in an amount that exceeds the lesser of:
  - The applicable cost sharing amount; or
  - The retail price of the drug in the absence of prescription drug coverage.

**Maximum Allowable Cost.** Current law defines the term "maximum allowable cost" (MAC), as the per-unit amount that a PBM reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.[25] The MAC represents the upper limit price that a plan sponsor will pay or reimburse for generic and brand-name drugs that have generic versions available.[26] The purpose of the MAC pricing list is to ensure that the pharmacy is motivated to seek and purchase generic drugs at the lowest price in the marketplace.

**Payment of claims.** Current law requires a PBM, acting on behalf of an insurer or HMO, to pay a provider's claim within a prescribed time.[27] Further, the Department of Financial Services reviews alleged violations, relating to claims of providers not paid or denied by the insurer or HMO.[28] The Agency for Health Care Administration (AHCA) administers the Statewide Provider and Health Plan Claim Dispute Resolution Program to assist contracted and noncontracted providers and health plans in resolving claim disputes that are not resolved by the provider and the health plan.[29] Dispute resolution services are available to Medicaid managed care providers and health plans. Claims submitted to managed care plans that have been denied in full or in part, or allegedly underpaid or overpaid may be eligible for dispute under the arbitration process.[30]

**Pharmacy Audits**

Pursuant to the Florida Pharmacy Act, a "pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, and an Internet pharmacy. The term "community pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[31] The term, "independent pharmacy," is not defined.

The audit process is one means used by PBMs and health plan sponsors to review payments to pharmacies. The audits are designed to ensure that procedures and reimbursement mechanisms

[25] Section 627.64741, F.S.
[26] Brent J. Eberle, RPh, Alan Van Amber, *Your PBM's MAC List Impacts Your Bottom Line,* Managed Healthcare Executive, (December 1, 2008), available at https://www.managedhealthcareexecutive.com/drug-costs/your-pbms-mac-list-impacts-your-bottom-line (last visited Feb. 12, 2020).
[27] *See* ss. 627.6131 and 641.3155, F.S.
[28] Department of Financial Services, *Medical Providers Information Memorandum, find out who to contact about your claim payment concerns* at https://apps.fldfs.com/eservice/MedicalProvider.aspx (last viewed Feb. 12, 2020).
[29] Section 408.7057, F.S.
[30] *Id.*
[31] Section 465.003(11), F.S.

are consistent with contractual and regulatory requirements.[32] Section 465.1885, F.S., prescribes the rights of a pharmacy in connection with an audit by a PBM, Medicaid managed care plan, or insurance company. These rights include:

- To be notified at least 7 calendar days before the initial onsite audit.
- To have the onsite audit scheduled after the first 3 calendar days of a month unless the pharmacist consents otherwise.
- To have the audit period limited to 24 months after the date a claim is submitted to or adjudicated by the entity.
- To have an audit that requires clinical or professional judgment conducted by or in consultation with a pharmacist.
- To use the written and verifiable records of a hospital, physician, or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law.
- To be reimbursed for a claim that was retroactively denied for a clerical error, typographical error, scrivener's error, or computer error if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged, or the error results in actual financial loss to the entity.
- To receive the preliminary audit report within 120 days after the conclusion of the audit.
- To produce documentation to address a discrepancy or audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.
- To receive the final audit report within 6 months after receiving the preliminary audit report.
- To have recoupment or penalties based on actual overpayments and not according to the accounting practice of extrapolation.

Neither the Department of Health nor the Board of Pharmacy has authority under ch. 465, F.S., the Florida Pharmacy Act, to enforce these provisions against any entity not complying with these requirements.

**State Group Insurance Program**

Under the authority of s. 110.123, F.S., the Department of Management Services (department), through the Division of State Group Insurance (DSGI), administers the State Group Insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code to provide prescription drug benefits for state employees and state university employees. To administer the program, the department contracts with third-party administrators for self-insured health plans, fully insured HMOs, and a Pharmacy Benefits Manager (PBM) for the self-insured State Employees' Prescription Drug Program (program) pursuant to s.110.12315, F.S.

The program has four dispensing avenues: participating 30-day retail pharmacies, participating 90-day retail pharmacies, the PBM's mail order pharmacies, and the PBM's specialty pharmacies. The retail network provides 3,961 pharmacies within the state of Florida and 59,520 nationally. The only chain pharmacy not included in the program's retail network is Walgreens.

[32] The Florida Senate, *CS/SB 702, Pharmacy Audits, Bill Analysis* (March 13, 2014).

During the invitation to negotiate process, the department determined that using a slightly less broad network provided significant savings to the program while having zero access disruption to members.[33] While the program does offer a mail order pharmacy network in the contract with the current PBM, members are not required to use mail order and may fill their prescriptions for up to a 90-day supply at network retail pharmacies that agree to the same pricing as the mail order. Contractually, and as stated in the benefit documents, specialty drugs, as defined by the PBM, must be dispensed by the PBM's specialty pharmacies. However, the first fill of oncology specialty drugs may be covered when dispensed by a network retail pharmacy. This process allows the patient to obtain the medication as soon as possible while providing time for the prescriber to get the patient set up at the PBM's specialty pharmacy. To assist members and prescribers, the PBM's specialty pharmacies have clinicians trained in each of the clinical disciplines, conditions, and specialties corresponding to the specialty drugs being dispensed.[34]

The program covers all federal legend drugs unless specifically excluded or if prescribed to treat a non-covered medical condition. The program does not have fail first requirements or step therapy. The contract between the PBM and the state requires that 100 percent of all manufacturer payments including rebates must be passed through to the state; and that spread pricing at retail pharmacies is prohibited.[35]

The health plans (PPO and HMOs) and the PBM on behalf of the program each apply their respective medical policy guidelines to determine medical necessity for drugs; none of the plans (medical and Rx) cover experimental and/or investigational drugs and treatments.[36]

Copayments (and coinsurance for high deductible plans) for each drug tier are the same for all members, as follows:

| **Drug Tier** | **Retail – Up to 30-Day Supply** | **Retail and Mail – Up to 90-Day Supply and Specialty Medications** |
|---|---|---|
| Generic | $7 | $14 |
| Preferred Brand | $30 | $60 |
| Non-Preferred Brand | $50 | $100 |

The State Group Insurance Program typically makes benefit changes on a plan year basis, which is January 1 through December 31. Benefit changes are subject to approval by the Legislature. The current PBM for the State Group Insurance Program is CaremarkPCS Health, LLC (CVS Caremark).[37]

[33] *See* Department of Management Services, *2020 Legislative Analysis of SB 1338 (Jan. 16, 2020).*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*

**Federal Regulations Relating to Medical Loss Ratios, Rebates, and Spread Pricing**

***Insurers, HMOs, and PBMs***

Health insurers and HMOs are required to report how much they spend on health care and how much they spend on administrative costs, such as salaries and marketing. If an insurer or HMO spends less than 80 percent (85 percent in the large group market) of premium on medical care and efforts to improve the quality of care, they must refund the portion of premium that exceeds this limit. The 80 percent (or 85 percent) is the medical loss ratio (MLR). The PBMs must report rebate information to the health insurers and HMOs, and the insurer or HMO includes this information as a deduction from the amount of incurred claims in the MLR reporting to the Department of Health and Human Services (HHS).[38] The Medicaid plans must also calculate and report MLRs, which must account for rebates and spread pricing, as described below.

***Medicaid***

According to the Centers for Medicare and Medicaid Services (CMS), states are increasingly reporting instances of spread pricing in Medicaid, including cases in Ohio and Texas, and CMS is concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers.[39] Further, if spread pricing is not monitored, a PBM can profit from charging health plans an excess amount above the amount paid to the pharmacy dispensing a drug, which increases Medicaid costs for taxpayers.[40]

According to CMS, spread pricing has been reported predominantly for generic prescriptions. States have raised concerns that PBMs can reimburse pharmacies for generic prescriptions based on lower pricing benchmarks than the benchmarks used for charging Medicaid and CHIP managed care plans for the same prescriptions. In response to these concerns, the CMS released guidance that prohibits PBMs using spread pricing to upcharge health plans and increase costs for states.[41] For purposes of the MLR regulation,[42] "prescription drug rebates" means any price concession or discount received by the managed care plan or by its PBM, regardless of who pays the rebate or discount.[43] Some possible examples include payments from pharmaceutical manufacturers, wholesalers, and retail pharmacies. Therefore, the amount retained by a PBM under spread pricing would have to be excluded from the amount of claims costs used for calculating the Medicaid managed care plan's MLR. The policy underlying this guidance is that spread pricing should not be used to artificially inflate a Medicaid or CHIP managed care plan's

[38] Section 2718 of the Public Health Service Act. The HHS has the authority to examine insurers and HMOs and their venders, such as PBMs.
[39] Centers for Medicare and Medicaid Services, *CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers* (May 15, 2019) at https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not (last viewed Jan. 3, 2020).
[40] *Id.*
[41] Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors* (May 15, 2019) https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf (last viewed Jan. 3, 2020).
[42] CMS regulations require Medicaid and CHIP managed care plans to report an MLR and use an MLR target of 85 percent in developing rates. The 85 percent target means that only 15 percent of the revenue for the managed care plan can be used for administrative costs and profits.
[43] 42 CFR 438.8(e)(2)(ii)(B).

MLR. For purposes of calculating the MLR, the Medicaid managed care regulations[44] require that prescription drug rebates received and accrued must be deducted from incurred claims. The CMS also interprets this requirement to apply equally regardless of whether the prescription drug rebate is received by the managed care plan (i.e., directly) or by a subcontractor (i.e., indirectly) administering the covered outpatient drug benefit on behalf of the managed care plan.[45]

When a managed care plan subcontracts with a third-party vendor to administer, and potentially provide, a portion of Medicaid covered services to enrollees, the subcontractor must report to the managed care plan all of the underlying data needed for the Medicaid managed care plan to calculate and report the managed care plan's MLR. The regulations at 42 CFR 438.8(k) also require states, through their contracts with managed care plans, to require each managed care plan to submit an annual MLR report.[46]

**Drug Pricing Transparency**

Due to a lack of transparency in the marketplace, it can be difficult to determine the final price of a prescription drug. Drug companies price discriminate, meaning they sell the same drug to different buyers (wholesalers, health plans, pharmacies, hospitals, government purchasers, and other providers) at different prices. The final price of a drug may include rebates and discounts to health plans and pharmacy benefit managers that are not disclosed. Market participants, such as wholesalers, add their own markups and fees. Drug manufacturers may offer direct consumer discounts, such as prescription drug coupons that can be redeemed when filling a prescription at a pharmacy.[47]

Drug pricing transparency requires manufacturers, PBMs, and others to expand public disclosures and report more information on drug pricing to the state or federal government. Strategies may be aimed at various parties:[48]

- Manufacturers – price increases, list prices, pricing policies.
- Pharmacy Benefit Managers (PBMs) – rebates, other roles.
- Insurers – formularies, cost sharing for brand and generic drugs, and utilization management techniques.
- Providers – price markups.
- State agencies – drug expenditures and usage trends.

***Federal Reporting***

Medicare Part D plans and qualified health plan issuers who have their own PBM or contract with a PBM are required to report to the U.S. Department of Health and Human Services (HHS) aggregate information about rebates, discounts, or price concessions that are passed through to the plan sponsor or retained by the PBM. In addition, the plans must report the difference

[44] *Id.*
[45] *Supra* note 41.
[46] 42 CFR 438.230(c)(1) and 42 CFR 438.8(k)(3).
[47] *See supra* note 3, 5 and 8.
[48] *Id.*

between the amount the plan pays the PBM and the amount that the PBM pays its suppliers (spread pricing). The reported information is confidential, subject to certain limited exceptions. [49]

***State Reporting***

In 2016, Vermont approved the first law requiring manufacturer disclosure for drugs that underwent large percentage price increases.[50] Each year, this law requires state regulators to compile a list of 15 drugs used by Vermont residents that experience the largest annual price increases. Manufacturers are required to justify the price increase to the Attorney General. The act requires the Attorney General to provide an annual report to the General Assembly based on the information the Office receives from manufacturers and to post the report on the Office's website.[51]

Oregon established a legislative task force in 2018 (HB 4005) that has developed more than a dozen recommendations for further work, including state agency reporting on the 10 most expensive drugs and the 10 with the highest price increases; manufacturer justification of high prices; insurer explanation of formulary practices; provider disclosure of markups; and evaluation of PBM rebates.[52] Maine also enacted a law in 2018 (LD 1406) requiring the state's All Payer Claims Database to annually report on the price of the state's most frequently prescribed and costliest prescription drugs, and to develop a plan for the collection of cost and pricing information from drug manufacturers.[53]

The California Drug Pricing Reporting Law (the law)[54] is designed to provide greater information about trends and factors relating to drug cost and pricing for policymakers and the public. The law imposes price justification, notification, and reporting requirements on pharmaceutical manufacturers for price increases on their drugs sold to state purchasers, insurers, and pharmacy benefit managers in California. The law requires manufacturers to notify state regulators regarding price increases, too. Further, the law requires insurers and health maintenance organizations to report specified cost information regarding covered prescription drugs and the impact of such cost on premiums. The state is required to compile such information and post the annual report on its website. The state may impose civil penalties against entities failing to comply with the reporting requirements. The law requires manufacturers to provide written notification to:

- Purchasers (insurers, HMOs, pharmacy benefit managers, and state agencies) of a drug price increase that exceeds 16 percent over a 2-year period for any drugs with a wholesale acquisition cost (WAC)[55] of greater than $40. The notice must include a statement regarding

[49] 42 U.S.C. s. 1320b-23.
[50] *See* https://legislature.vermont.gov/Documents/2016/Docs/ACTS/ACT165/ACT165%20Act%20Summary.pdf (last viewed Jan. 11, 2020).
[51] *Id*.
[52] Oregon Legislative Assembly, *HB 4005, Prescription Drug Transparency Act*, 2018.
[53] Ario, Joel, *Strategies to Expand Transparency, Enhance Competition and Control Costs: A Toolkit for Insurance Regulators Manatt Health Strategies* (Jul. 2019) at https://www.naic.org/meetings1908/cmte_b_health_inn_wg_2019_summer_nm_materials_strategies.pdf (last viewed Jan. 3, 2020).
[54] See Cal. Health & Safety Code s. 1367.243, s. 1385.045, s. 127280, s. 127675, s. 127676, s. 127677, s. 127679, s. 127681, s. 127683, s. 127685, and s. 127686 (Senate Bill No. 17, 2017).
[55] Under federal law, the term "wholesale acquisition cost" means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other

whether a change or improvement in the drug necessitates the price increase, and if applicable, a description of such change or improvement. This notification must be provided at least 60 days prior to the effective date of the increase.
- The state for each drug for which an increase in WAC, as described above, occurs, or other specified drug price increases. Manufacturers must provide information regarding such drug's indication and dosage, factors used to increase the WAC, and marketing materials.

In the notice to purchasers, as described above, the manufacturer may limit the disclosure to information that it is in the public domain. The state is required to publish on the internet information submitted by manufacturers to the state, as described above, in a manner that identifies the information on a per-drug basis.[56]

## III. Effect of Proposed Changes:

**Section 1** amends s. 624.3161, F.S., to authorize the OIR to conduct market conduct examinations of PBMs.

**Section 2** transfers s. 465.1885, F.S., and renumbers the section as s. 624.491, F.S., and amends the section to clarify existing requirements and limitations for pharmacy audits by an insurer or HMO or an entity on behalf of the insurer or HMO, including but not limited to a PBM. The bill transfers pharmacy audit provisions from the Florida Pharmacy Act to the Florida Insurance Code.

The bill clarifies that a health insurer or HMO remains responsible for any violations of the pharmacy auditing requirements and payment of claims violations by a PBM acting on its behalf. The bill also allows a pharmacy to appeal final audit findings related to claim payments with the Statewide Provider and Health Plan Claim Dispute Resolution Program administered by the AHCA.

**Section 3** creates s. 624.492, F.S., to require health insurers and HMOs, or a PBM acting on behalf of a health insurer or HMO, to report to the OIR annually by March 1. Consistent with federal reporting requirements and to increase PBM transparency, the report must contain the following information for the preceding policy or contract year:
- The total number of prescriptions that were dispensed.
- The number and percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies.
- The general dispensing rate, which is the number and percentage of prescriptions for which a generic drug was available and dispensed.
- The aggregate amount and types of rebates, discounts, price concessions, or other earned revenues that the health insurer, HMO, or PBM negotiated for and are attributable to patient utilization under the plan, excluding bona fide service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs.

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discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. *See* 42 U.S. Code s. 1395w–3a.

[56] *Supra* note 53.

- If negotiated by the PBM, the aggregate amount of the rebates, discounts, or price concessions, which were passed through to the health insurer or HMO. These provisions are consistent with the current federal PBM transparency reporting requirements.
- If the health insurer or HMO contracted with a PBM, the aggregate amount of the difference between the amount the health insurer or HMO paid the PBM and the amount the PBM paid retail pharmacies and mail order pharmacies.

The bill also requires PBMs that submit the above information to the OIR must also provide the information to the health insurer and the HMO with which the PBM is under contract.

**Sections 4, 5, and 6** amend ss. 627.64741, 627.6572, and 641.14, F.S., , relating to individual health insurance policies, group health insurance policies, and HMO contracts, respectively.

The bill allows the OIR to require health insurers and HMOs to submit PBM contracts to the office for review and allows the OIR to order the insurer or HMO to cancel the contract (in accordance with the contract terms and applicable law) if any of the following conditions exist:
- Unreasonably high PBM fees that are detrimental to the policyholders or subscribers of the insurer;
- Noncompliance with the Florida Insurance Code; or
- The PBM is not registered with the OIR pursuant to s. 624.490, F.S.

**Section 7** provides that the bill takes effect July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

### A. Tax/Fee Issues:

None.

### B. Private Sector Impact:

PCS/CS/SB 1338 will increase the administrative costs of health insurers, HMOs, and PBMs due to the bill's requirements that:[57,58]

- The OIR conduct market examinations of PBMs; and
- Health insurers, HMOs, and PBMs submit an annual report to the OIR.

### C. Government Sector Impact:

The bill has an indeterminate negative fiscal impact on state expenditures due to the bill's impact to the administrative costs of health insurers, HMOs, and PBMs. To the extent that these administrative costs are passed down to customers, such as DSGI, there will be a fiscal impact.[59]

According to the OIR, the bill will increase state expenditures. Specifically, the OIR will need pharmacy-related training and/or to contract with a pharmacist in order to provide effective oversight of PBM market conduct examinations and respond to any complaints involving pharmacy audits. According to the OIR the minimum estimated cost to contract with a pharmacist would be $100,000 to $200,000.[60]

## VI. Technical Deficiencies:

Sections 4, 5, and 6 include terms, which are not defined, such as "pharmacy services administrative organization", "rebate", and "other financial benefit."

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.3161, 627.64741, 627.6572, and 641.314.

This bill creates section 624.492 of the Florida Statutes.

This bill repeals section 465.1885 of the Florida Statutes.

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[57] Department of Management Services, *2020 Agency Legislative Bill Analysis of SB 1338* (Jan. 16, 2020).
[58] Office of Insurance Regulation, *2020 Agency Legislative Bill Analysis of SB 1338* (Jan. 2, 2020).
[59] *Id.* and *supra* note 46.
[60] *Supra* note 47.

## IX. Additional Information:

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

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 25, 2020:**
The committee substitute removes the definitions of brand-name drug and generic drug and reverts to the current law definition of maximum allowable cost. The committee substitute also removes the requirement that contracts between a PBM and pharmacy or PSAO include:

- Drugs identified as brand-name drugs must be considered brand-name drugs for all purposes under an agreement, contract, or amendment to a contract.
- Single source generic drugs with only one manufacturer must be reimbursed as if they are a brand-name drug.
- Drugs identified as a generic drugs must be considered generic drugs for all purposes under an agreement, contract, or amendment to a contract.
- Rebates and other financial benefits for generic drugs provided to the PBM must be passed through to the health insurer or HMO.

**Banking and Insurance on January 28, 2020:**
The CS provides a technical change to correct a scrivener's error.

B. Amendments:

None.

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

25 Feb 20
*Meeting Date*

1338
*Bill Number (if applicable)*

Topic Prescription Drug Coverage
*Amendment Barcode (if applicable)*

Name Barney Bishop III

Job Title CEO

Address 2215 Thomasville Road
*Street*
Tallahassee FL 32308
*City* *State* *Zip*

Phone 850.510.9922

Email barney@barneybishop.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Smart Justice Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

SB 1338
*Bill Number (if applicable)*

Topic PBM

*Amendment Barcode (if applicable)*

Name ~~Shane Abbott~~ Shane Abbott

Job Title Pharmacist

Address 1061 S 2nd Street
*Street*

Phone 850-333-0747

DeFuniak Springs FL 32435
*City* *State* *Zip*

Email NFR498@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing The Prescription Place

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

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2/25/20
*Meeting Date*

1338
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Chris Nuland

Job Title _____

Address 4427 Herschel Street
*Street*

Jacksonville, FL 32210
*City* *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Gastroenterologic Society

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 1838
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Jeff Kottkamp

Job Title _____

Address _____ Phone _____

*Street*

Tallahassee FL _____ Email _____

*City* *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against

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

Representing Small Business Pharmacies Alliance for Reform

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

1338
*Bill Number (if applicable)*

Topic PBM

*Amendment Barcode (if applicable)*

Name ALEX HERWIG

Job Title PHARMACIST

Address 43 EAST AVE
*Street*

Phone

NAPLES FL 34108
*City* *State* *Zip*

Email ALEX@G4IFSHORERX.COM

Speaking: ☐ For ☐ Against ☐ Information

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

Representing SPAR SMALL BUSINESS PHARMACIES ALIGNED FOR REFORM

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

2-25-20 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 1338

*Meeting Date* *Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic PBMs + Medicaid

Name Kevin Duane

Job Title Pharmacist

Address 2579 Karatas Ct Phone 904-422-5643

*Street*

Jacksonville FL 32246 Email KJDuane@gmail.com

*City* *State* *Zip*

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

Waive Speaking: [ ] In Support [ ] Against

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

Representing SPAR

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

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

1338
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Prescription Drug Coverage

Name John O'Brien

Job Title

Address 750 N. Tamiami Trl
*Street*

Sarasota FL 34236
*City* *State* *Zip*

Phone

Email

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

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

Representing Florida Pharmacy Association

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

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

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

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

1338
*Bill Number (if applicable)*

Topic Prescription Drug Coverage/PBM Reform
*Amendment Barcode (if applicable)*

Name Michael Fischer

Job Title

Address 201 S. Monroe, 5th Floor
*Street*

Phone 850-329-6165

TLH | FL | 32301
*City* | *State* | *Zip*

Email mike@legisgroupfl.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Independent Pharmacy Network

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

SB 1338
*Bill Number (if applicable)*

Topic Prescription Drug Coverage

*Amendment Barcode (if applicable)*

Name Scott Woods

Job Title Assistant Vice President, State Affairs

Address 325 7th St NW, 9th Floor
*Street*

Phone 202-756-5736

Washington DC 20004
*City* *State* *Zip*

Email Swoods@pcmanet.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Pharmaceutical Care Management Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

February 25, 2020
*Meeting Date*

CS/SB 1338
*Bill Number (if applicable)*

Topic PRESCRIPTION DRUG COVERAGE

*Amendment Barcode (if applicable)*

Name Michael Jackson

Job Title Executive Vice President and CEO

Address 610 North Adams Street
*Street*

Phone (850) 222-2400

Tallahassee — *City* | Florida — *State* | 32301 — *Zip*

Email mjackson@pharmview.com

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

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

Representing Florida Pharmacy Association

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

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

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S-001 (10/14/14)

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/~~2019~~ 2020 ajp
*Meeting Date*

SB1338
*Bill Number (if applicable)*

Topic Prescription Drug Coverage
*Amendment Barcode (if applicable)*

Name David Poole

Job Title Director Legislative Affairs

Address 1825 Country Club Dr
*Street*
Tallahassee FL 32301
*City* *State* *Zip*

Phone 850-766-3323

Email david.poole@aidshealth.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing AIDS Healthcare Foundation (AHF)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

| Meeting Date | Bill Number (if applicable) |
|---|---|
| | 1338 |

Amendment Barcode (if applicable)

Topic Pharmacy

Name Cynthia Henderson

Job Title

Address _____ Phone 8505590855

*Street*

_____ Email cyhenderson@me.com

*City* *State* *Zip*

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

Waive Speaking: [X] In Support [ ] Against

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

Representing EPIC

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

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

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S-001 (10/14/14)

**By** the Committee on Banking and Insurance; and Senators Wright and Harrell

597-02766-20 20201338c1

A bill to be entitled

An act relating to prescription drug coverage; amending s. 624.3161, F.S.; authorizing the Office of Insurance Regulation to examine pharmacy benefit managers; specifying that certain examination costs are payable by persons examined; transferring, renumbering, and amending s. 465.1885, F.S.; revising entities conducting pharmacy audits to which certain requirements and restrictions apply; authorizing audited pharmacies to appeal certain findings; providing that health insurers and health maintenance organizations that transfer a certain payment obligation to pharmacy benefit managers remain responsible for certain violations; creating s. 624.492, F.S.; providing applicability; requiring health insurers and health maintenance organizations, or pharmacy benefit managers on behalf of health insurers and health maintenance organizations, to annually report specified information to the office; requiring reporting pharmacy benefit managers to also provide the information to health insurers and health maintenance organizations they contract with; authorizing the Financial Services Commission to adopt rules; amending ss. 627.64741, 627.6572, and 641.314, F.S.; defining and redefining terms; specifying requirements relating to brand-name and generic drugs in contracts between pharmacy benefit managers and pharmacies or pharmacy services administration organizations; requiring an agreement for pharmacy







597-02766-20 20201338c1

benefit managers to pass through certain financial benefits to the individual or group health insurer or health maintenance organization, respectively; authorizing the office to require health insurers or health maintenance organizations to submit certain contracts or contract amendments to the office; authorizing the office to order insurers or health maintenance organizations to cancel such contracts under certain circumstances; authorizing the commission to adopt rules; revising applicability; providing an effective date.

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

Section 1. Subsections (1) and (3) of section 624.3161, Florida Statutes, are amended to read:

624.3161 Market conduct examinations.—

(1) As often as it deems necessary, the office shall examine each pharmacy benefit manager, each licensed rating organization, each advisory organization, each group, association, carrier, as defined in s. 440.02, or other organization of insurers which engages in joint underwriting or joint reinsurance, and each authorized insurer transacting in this state any class of insurance to which the provisions of chapter 627 are applicable. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of chapters 440, 624, 626, 627, and 635.

(3) The examination may be conducted by an independent

professional examiner under contract to the office, in which case payment shall be made directly to the contracted examiner by the insurer or person examined in accordance with the rates and terms agreed to by the office and the examiner.

Section 2. Section 465.1885, Florida Statutes, is transferred, renumbered as s. 624.491, Florida Statutes, and amended to read:

624.491 ~~465.1885~~ Pharmacy audits; rights.—

(1) A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health insurance policy or health maintenance contract, respectively, shall comply with the requirements of this section when the insurer or health maintenance organization or any entity acting on behalf of the insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager, audits the records of a pharmacy licensed under chapter 465. Such audit must comply with the following requirements ~~If an audit of the records of a pharmacy licensed under this chapter is conducted directly or indirectly by a managed care company, an insurance company, a third-party payor, a pharmacy benefit manager, or an entity that represents responsible parties such as companies or groups, referred to as an "entity" in this section, the pharmacy has the following rights~~:

(a) The pharmacy must ~~To~~ be notified at least 7 calendar days before the initial onsite audit for each audit cycle.

(b) An ~~To have the~~ onsite audit may not be scheduled during ~~after~~ the first 3 calendar days of a month unless the pharmacist consents otherwise.

(c) The scope of ~~To have~~ the audit period must be limited







to 24 months after the date a claim is submitted to or adjudicated by the entity.

(d) ~~To have~~ An audit that requires clinical or professional judgment must be conducted by or in consultation with a pharmacist.

(e) A pharmacy may ~~To~~ use the written and verifiable records of a hospital, physician, or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law.

(f) A pharmacy must ~~To~~ be reimbursed for a claim that was retroactively denied for a clerical error, typographical error, scrivener's error, or computer error if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged, or the error results in actual financial loss to the entity.

(g) A copy of ~~To receive~~ the preliminary audit report must be provided to the pharmacy within 120 days after the conclusion of the audit.

(h) A pharmacy may ~~To~~ produce documentation to address a discrepancy or audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.

(i) A copy of ~~To receive~~ the final audit report must be provided to the pharmacy within 6 months after receipt of ~~receiving~~ the preliminary audit report.

(j) Any ~~To have~~ recoupment or penalties must be calculated based on actual overpayments and not according to the accounting practice of extrapolation.

(2) ~~The rights contained in~~ This section does ~~do~~ not apply

to:

(a) Audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods;

(b) Audits of claims paid for by federally funded programs; or

(c) Concurrent reviews or desk audits that occur within 3 business days after ~~of~~ transmission of a claim and where no chargeback or recoupment is demanded.

(3) An entity that audits a pharmacy located within a Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force area designated by the United States Department of Health and Human Services and the United States Department of Justice may dispense with the notice requirements of paragraph (1)(a) if such pharmacy has been a member of a credentialed provider network for less than 12 months.

(4) Pursuant to s. 408.7057 and after receipt of the final audit report issued by the health insurer or health maintenance organization, a pharmacy may appeal the findings of the final audit as to whether a claim payment is due or the amount of a claim payment.

(5) If a health insurer or health maintenance organization transfers to a pharmacy benefit manager through a contract the obligation to pay any pharmacy licensed under chapter 465 for any pharmacy benefit claims arising from services provided to or for the benefit of any insured or subscriber, the health insurer or health maintenance organization remains responsible for any violations of this section, s. 627.6131, or s. 641.3155.





Section 3. Section 624.492, Florida Statutes, is created to read:

624.492 Health insurer, health maintenance organization, and pharmacy benefit manager reporting requirements.—

(1) This section applies to:

(a) A health insurer or health maintenance organization issuing, delivering, or issuing for delivery comprehensive major medical individual or group insurance policies or health maintenance contracts, respectively, in this state; and

(b) A pharmacy benefit manager providing pharmacy benefit management services on behalf of a health insurer or health maintenance organization described in paragraph (a) and managing prescription drug coverage under a contract with the health insurer or health maintenance organization.

(2) By March 1 annually, a health insurer or health maintenance organization, or a pharmacy benefit manager on behalf of a health insurer or health maintenance organization, shall report, in a form and manner as prescribed by the commission, the following information to the office with respect to services provided by the health insurer or health maintenance organization, or the pharmacy benefit manager on behalf of the insurer or health maintenance organization, for the immediately preceding policy or contract year:

(a) The total number of prescriptions that were dispensed.

(b) The number and percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies. This paragraph applies to pharmacies licensed under chapter 465 which dispense drugs to the general public and which were paid by the health insurer, health maintenance

organization, or pharmacy benefit manager under the contract.

(c) For retail pharmacies and mail-order pharmacies described in paragraph (b), the general dispensing rate, which is the number and percentage of prescriptions for which a generic drug was available and dispensed.

(d) The aggregate amount and types of rebates, discounts, price concessions, or other earned revenues that the health insurer, health maintenance organization, or pharmacy benefit manager negotiated for and are attributable to patient utilization under the plan, excluding bona fide service fees that include, but are not limited to, distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs.

(e) If negotiated by the pharmacy benefit manager, the aggregate amount of the rebates, discounts, or price concessions under paragraph (d) which were passed through to the health insurer or health maintenance organization.

(f) If the health insurer or health maintenance organization contracted with a pharmacy benefit manager, the aggregate amount of the difference between the amount the health insurer or health maintenance organization paid the pharmacy benefit manager and the amount the pharmacy benefit manager paid retail pharmacies and mail order pharmacies.

(3) A pharmacy benefit manager that reports the information under subsection (2) to the office shall also provide the information to the health insurer or health maintenance organization with which the pharmacy benefit manager is under contract.





(4) The commission may adopt rules to administer this section.

Section 4. Section 627.64741, Florida Statutes, is amended to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Brand-name drug" means a drug that:

1. Is a brand drug described by Medi-Span and has a multisource code field containing an "M" (cobranded product), an "O" (originator brand), or an "N" (single-source brand), except for a drug with a multisource code of "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent brand drug designation in the First Databank FDB MedKnowledge database.

(b) "Generic drug" means a drug that:

1. Is a generic drug described by Medi-Span and has a multisource code field containing a "Y" (generic), or an "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent generic drug designation in the First Databank FDB MedKnowledge database.

(c) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug:

1. As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand-name drug, biological product, or specialty drug;

2. Which amount must be based on pricing published in the Medi-Span Master Drug Database, or, if the pharmacy benefit

manager uses only First Databank FDB MedKnowledge, must be based on pricing published in First Databank FDB MedKnowledge; and

3. ~~,~~ Excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(d)~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c)~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d)~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that







exceeds the lesser of:

1.~~(a)~~ The applicable cost-sharing amount; or

2.~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) A drug identified as a brand-name drug must be considered a brand-name drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administration organization on behalf of the pharmacy. A single-source generic drug with only one manufacturer must be reimbursed as if it were a brand-name drug.

(4) A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administrative organization acting on behalf of the pharmacy. The pharmacy benefit manager and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, shall agree that if the pharmacy benefit manager is provided any rebate or other financial benefit for any drug identified as a generic drug, the pharmacy benefit manager must pass through all such rebates or other financial benefits to the health insurer.

(5) The office may require a health insurer to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(6) After review of a contract under subsection (5), the office may order the insurer to cancel the contract in accordance with the terms of the contract and applicable law if

the office determines that any of the following conditions exist:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(7) The commission may adopt rules to administer this section.

(8)~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 5. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Brand-name drug" means a drug that:

1. Is a brand drug described by Medi-Span and has a multisource code field containing an "M" (cobranded product), an "O" (originator brand), or an "N" (single-source brand), except for a drug with a multisource code of "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent brand drug designation in the First Databank FDB MedKnowledge database.

(b) "Generic drug" means a drug that:

1. Is a generic drug described by Medi-Span and has a







multisource code field containing a "Y" (generic), or an "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent generic drug designation in the First Databank FDB MedKnowledge database.

(c) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug:

1. As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand-name drug, biological product, or specialty drug;

2. Which amount must be based on pricing published in the Medi-Span Master Drug Database, or, if the pharmacy benefit manager uses only First Databank FDB MedKnowledge, must be based on pricing published in First Databank FDB MedKnowledge; and

3. ~~,~~ Excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(d)~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or

modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

2. ~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) A drug identified as a brand-name drug must be considered a brand-name drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and pharmacy, or a pharmacy services administration organization on behalf of the pharmacy. A single-source generic drug with only one manufacturer must be reimbursed as if it were a brand-name drug.

(4) A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administrative organization acting on behalf of the pharmacy. The pharmacy benefit manager







and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, shall agree that if the pharmacy benefit manager is provided any rebate or other financial benefit for any drug identified as a generic drug, the pharmacy benefit manager must pass through all such rebates or other financial benefits to the health insurer.

(5) The office may require a health insurer to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(6) After review of a contract under subsection (5), the office may order the insurer to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exist:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(7) The commission may adopt rules to administer this section.

(8) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 6. Section 641.314, Florida Statutes, is amended to

read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Brand-name drug" means a drug that:

1. Is a brand drug described by Medi-Span and has a multisource code field containing an "M" (cobranded product), an "O" (originator brand), or an "N" (single-source brand), except for a drug with a multisource code of "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent brand drug designation in the First Databank FDB MedKnowledge database.

(b) "Generic drug" means a drug that:

1. Is a generic drug described by Medi-Span and has a multisource code field containing a "Y" (generic), or an "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent generic drug designation in the First Databank FDB MedKnowledge database.

(c) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug:

1. As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand-name drug, biological product, or specialty drug;

2. Which amount must be based on pricing published in the Medi-Span Master Drug Database, or, if the pharmacy benefit manager uses only First Databank FDB MedKnowledge, must be based on pricing published in First Databank FDB MedKnowledge; and

3. ~~,~~ Excluding dispensing fees, prior to the application of





copayments, coinsurance, and other cost-sharing charges, if any.

(d)~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(2) A health maintenance organization may contract only with a pharmacy benefit manager that ~~A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c)~~(3)~~ Does not limit ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d)~~(4)~~ Does not require ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1.~~(a)~~ The applicable cost-sharing amount; or

2.~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) A drug identified as a brand-name drug must be considered a brand-name drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administration organization on behalf of the pharmacy. A single-source generic drug with only one manufacturer must be reimbursed as if it were a brand-name drug.

(4) A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administrative organization acting on behalf of the pharmacy. The pharmacy benefit manager and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, shall agree that if the pharmacy benefit manager is provided any rebate or other financial benefit for any drug identified as a generic drug, the pharmacy benefit manager must pass through all such rebates or other financial benefits to the health maintenance organization.

(5) The office may require a health maintenance organization to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the health maintenance organization.

(6) After review of a contract under subsection (5), the office may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the





following conditions exist:

(a) The fees to be paid by the health maintenance organization are so unreasonably high as compared with similar contracts entered into by health maintenance organizations, or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances, that the contract is detrimental to the subscribers of the health maintenance organization.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(7) The commission may adopt rules to administer this section.

(8)~~(5)~~ This section applies to pharmacy benefit manager contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 7. This act shall take effect July 1, 2020.

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LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Wright) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 210 - 508

and insert:

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) "Pharmacy benefit manager" means a person or entity


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doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

2. ~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) The office may require a health insurer to submit to

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the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(4) After review of a contract under subsection (3), the office may order the insurer to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exist:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(5) The commission may adopt rules to administer this section.

(6) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 5. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing


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charges, if any.

(b) "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

2. ~~(b)~~ The retail price of the drug in the absence of



prescription drug coverage.

(3) The office may require a health insurer to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(4) After review of a contract under subsection (3), the office may order the insurer to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exist:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(5) The commission may adopt rules to administer this section.

(6)~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 6. Section 641.314, Florida Statutes, is amended to read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a


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prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(2) A health maintenance organization may contract only with a pharmacy benefit manager that ~~A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ a subscriber to make a payment for a prescription drug at the


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point of sale in an amount that exceeds the lesser of:

1.~~(a)~~ The applicable cost-sharing amount; or

2.~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) The office may require a health maintenance organization to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the health maintenance organization.

(4) After review of a contract under subsection (3), the office may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exist:

(a) The fees to be paid by the health maintenance organization are so unreasonably high as compared with similar contracts entered into by health maintenance organizations, or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances, that the contract is detrimental to the subscribers of the health maintenance organization.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(5) The commission may adopt rules to administer this section.

(6)~~(5)~~ This section applies to pharmacy benefit manager

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185 ================= T I T L E  A M E N D M E N T ================
186 And the title is amended as follows:
187 Delete lines 25 - 35
188 and insert:
189 F.S.; authorizing the office to require health
190 insurers or health maintenance organizations to submit
191 to the office certain contracts or contract amendments
192 entered into with pharmacy benefit managers;

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1544 |
| INTRODUCER: | Health Policy Committee and Senator Albritton |
| SUBJECT: | Long-term Care |
| DATE: | February 24, 2020 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Looke | Brown | HP | **Fav/CS** |
| 2. | McKnight | Kidd | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 1544 amends s. 409.979, F.S., to provide additional clarity for individuals on the Medicaid Long-Term Care Managed Care waitlist regarding the likelihood that he or she will be eligible for services through the program and amends s. 430.205, F.S., to allow a community-care-for-the-elderly service provider to dispute a referral from protective investigations of an elderly adult determined to be in need of services or to be the victim of abuse.

The bill has an insignificant fiscal impact to the Department of Elder Affairs that can be absorbed with existing resources.[1] See Section V.

The bill takes effect on July 1, 2020.

## II. Present Situation:

### Statewide Medicaid Managed Care

The Statewide Medicaid Managed Care (SMMC) program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all

[1] Department of Elder Affairs, *SB 1544 Bill Analysis* (Jan. 23, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

health care services, rather than various entities.[2] The SMMC program is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds.[3] Eligibility for the SMMC program is determined by the Department of Children and Families (DCF).[4]

Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees. The Long-Term Care Managed Care (LTC) Program provides services to frail elderly or disabled Medicaid recipients in nursing facilities and in community settings, including an individual's home, an assisted living facility, or an adult family care home.

Implementation of the LTC Program required approval by the federal Centers for Medicare & Medicaid Services (CMS) by virtue of 1915(b) and (c) waivers submitted by the AHCA. The waivers were approved on February 1, 2013, and authorized the LTC Program to operate effective July 1, 2013, through June 30, 2016.[5] Initial enrollment into the LTC Program began August 1, 2013. The current LTC Program waiver is authorized through December 27, 2021.[6]

***Long-Term Care Program***

The LTC Program provides long term care services, including nursing facility and home and community based services, to eligible Medicaid recipients.

Federal law requires state Medicaid programs to provide nursing facility services to individuals, age 21 or older, who are in need of nursing facility care.[7] States are prohibited from limiting access to nursing facility services, but the provision of home and community-based services is optional.[8] Home and communitybased services in Florida are delivered through a federal 1915(c), home and community-based services waiver.[9] The waiver establishes that home and community based LTC services are available to qualified recipients, subject to an enrollment cap. As such, the LTC program is managed based on a priority enrollment system and a waitlist for individuals who are not high-priority clients. Delivery of home and communitybased services to eligible recipients is dependent on the availability of annual funding.

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[2] This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.
[3] Section 409.963, F.S.
[4] *Id.*
[5] Letter from U.S. Department of Health and Human Services, Disabled and Elderly Health Programs Group to Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration (February 1, 2013), *available at* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited Jan. 31, 2020).
[6] Letter from U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Division of Medicaid & Children's Health Operations to Beth Kidder, Interim Deputy Secretary for Medicaid, Agency for Health Care Administration (December 19, 2016), *available at* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf (last visited Feb. 19, 2020).
[7] Medicaid.gov, *Nursing Facilities, available at* https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html (last visited Jan. 31, 2020).
[8] *Id.*
[9] Section 409.906(13), F.S.

As of December 31, 2019, there were 116,507 individuals enrolled in the LTC Program, including 65,822 individuals enrolled in the home and community-based services portion of the LTC Program, and 50,685 individuals receiving nursing facility services.[10]

Long-Term Care Managed Care plans are required to, at a minimum, cover the following:

- Nursing facility care;
- Services provided in assisted living facilities;
- Hospice;
- Adult day care;
- Medical equipment and supplies, including incontinence supplies;
- Personal care;
- Home accessibility adaptation;
- Behavior management;
- Home-delivered meals;
- Case Management;
- Occupation therapy;
- Speech therapy;
- Respiratory therapy;
- Physical therapy;
    - Intermittent and skilled nursing;
    - Medication administration;
    - Medication Management;
    - Nutritional assessment and risk reduction;
    - Caregiver training;
    - Respite care;
    - Transportation; and
    - Personal emergency response systems.[11]

***LTC Program Eligibility***

To be eligible for the LTC Program, an individual must:

- Be age 65 or older and eligible for Medicaid, or age 18 or older and eligible for Medicaid by reason of a disability;
- Have annual income at or below 222 percent of the federal poverty level (FPL);[12] and,
- Be in need of nursing home care, as determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program.[13]

In addition, an individual seeking Medicaid eligibility must demonstrate that he or she meets limits on personal assets. Both federal and state law set parameters for Medicaid LTC eligibility

[10] Agency for Health Care Administration, *SMMC LTC Enrollment by County/Plan Report* (as of December 31, 2019), *available at* http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Jan. 31, 2020).
[11] Section 409.98, F.S.
[12] This equates to $28,327 for an individual and $38,273 for a family of two. For 2020 FPL standards, see U.S. Department of Health and Human Services, *HHS Poverty Guidelines for 2020* (January 8, 2020), *available at* https://aspe.hhs.gov/poverty-guidelines (last visited Jan. 31, 2020).
[13] Section 409.979(1), F.S.

based on personal property, such as a home or vehicle, and on financial assets, such as bank accounts, stocks and bonds, and life insurance policies.[14] Life insurance policies with a cash value greater than $1,500 may not be retained by individuals seeking Medicaid eligibility. Generally, assets above certain cash thresholds must be divested at least 60 months prior to a period of Medicaid eligibility.[15]

When determining the need for nursing facility care, the Department of Elder Affairs (DOEA) considers the nature of the services prescribed, the level of nursing or other health care personnel necessary to provide such services, and the availability of and access to community or alternative resources.[16] Imminent risk of nursing home placement can be evidenced by the need for medical observation throughout a 24-hour period and the need for care performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional. An individual at risk of nursing home care requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation.[17]

***LTC Program Enrollment***

The DOEA administers programs and services for elders through 11 Area Agencies on Aging (AAAs), which also operate Aging and Disability Resource Centers (ADRCs). The ADRCs provide information and referral services to individuals seeking long-term care services and also screen individuals for eligibility for long-term care services.

The LTC Program enrollment process is administered by the DOEA, the Department of Children and Families (DCF), and the AHCA. An individual in need of services or seeking services must contact the appropriate ADRC to request a screening. The screening is intended to provide the ADRC with information describing the individual's level of frailty. During the screening, the ADRC gathers basic information about the individual, including general health information and any assistance the individual needs with activities of daily living. Based on the screening, the individual receives a priority score, which indicates the level of need for services and reflects the level of the individual's frailty. Using the priority score, the individual is then placed on the waitlist. An individual seeking LTC services may request a rescreening any time his or her circumstances change. In addition, ADRC staff are required to rescreen waitlisted individuals on an annual basis.[18]

The prioritization of the waitlist is not described in statute but rather in administrative rule promulgated by the AHCA.[19] The rule sets five frailty-based levels based on the priority score calculation by the DOEA. The levels rank the individual's level of need in ascending order,

[14] U.S. Department of Health and Human Services, *Financial Requirements – Assets* (last modified October 10, 2017), *available at* https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets.html (last visited Jan. 31, 2020).
[15] 42 U.S.C. §1396p. See also Agency for Health Care Administration, *Medicaid State Plan Attachments – Eligibility Conditions and Requirements*, available at https://ahca.myflorida.com/medicaid/stateplan_attach.shtml (last visited Jan. 31, 2020).
[16] Section 409.985(3), F.S.
[17] Section 409.985(3), F.S.
[18] Section 409.979(3), F.S.
[19] Rule 59G-4.193, F.A.C.

meaning that an individual with a priority score of "1" has very low needs and an individual with a priority score of "5" has very high needs.

When funding becomes available, the frailest individuals are taken off the waitlist first, based upon priority score. The individual must then go through a comprehensive face-to-face assessment conducted by the local CARES staff.[20] After CARES confirms the medical eligibility of the individual, the DCF determines the financial eligibility of the individual. If the individual is approved for both medical and financial eligibility, the AHCA must notify him or her and provide information on selecting a long-term care managed care plan.

Because the waitlist is prioritized, it is highly unlikely that individuals with low priority scores will actually receive services. It is the DOEA's current practice to add any individual who completes the initial needs screening to the wait list, even if he or she has very limited need for services and is unlikely to qualify for services in the near future. This approach may be confusing to individuals with low priority scores, giving the impression that services will become available at some point in time. In practice, only individuals with high priority scores will receive services. Current law stipulates an individual may request a rescreening if his or her circumstances change, which allows individuals with low priority scores the ability to move up the waitlist if need can be demonstrated.

**Community Care for the Elderly**

The Community Care for the Elderly (CCE) program provides community-based services in a continuum of care to help elders with functional impairments to live in the least restrictive and most cost-effective environment suitable to their needs.[21]

The CCE program provides a wide range of services to clients, depending on their needs. These services include, but are not limited to, adult day care, chore assistance, counseling, home-delivered meals, home nursing, legal assistance, material aid, medical therapeutic services, personal care, respite, transportation, and other community-based services. [22]

The DOEA administers the program through contracts with AAAs, which subcontract with CCE Lead Agencies. Service delivery is provided by 52 Lead Agencies around the state. The CCE program is not a component of Medicaid but rather is funded by a combination of state general

[20] Florida Department of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, available at http://elderaffairs.state.fl.us/doea/cares.php (last visited Jan. 24, 2020). Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants. A registered nurse or assessor performs client assessments. A physician or registered nurse reviews each application to determine the level of care that is most appropriate for the applicant. The assessment identifies long-term care needs, and establishes the appropriate level of care (medical eligibility for nursing facility care), and recommends the least restrictive, most appropriate placement. Federal law also mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through Medicaid waivers.

[21] Section 430.202, F.S.

[22] Department of Elderly Affairs, *2019 Summary of Programs and Services – Section C: State General Revenue Programs* (January 2019), *available at* http://elderaffairs.state.fl.us/doea/sops.php (last visited Jan. 31, 2020).

revenue and client contributions. Clients are assessed a co-payment based on a sliding scale developed by the DOEA.[23]

To be eligible for the CCE program, an individual must be age 60 or older and functionally impaired,[24] as determined by an initial comprehensive assessment and annual reassessments. Primary consideration for services is given to elders referred to the DCF's Adult Protective Services (APS) and determined by APS to be victims of abuse, neglect, or exploitation and in need of immediate services to prevent further harm.[25] Individuals not referred by APS may still receive services, but according to a prioritization which is based upon the potential recipient's frailty level and likelihood of institutional placement. The DOEA is also required to consider an applicant's income when prioritizing services. Those less able to pay for services must receive higher priority than those with a greater ability to pay for services.[26]

## III. Effect of Proposed Changes:

**Section 1** amends s. 409.979, F.S., to specify that Medicaid Long-Term Care Managed Care eligibility screenings, both annual and upon notification of a significant change in an individual's circumstances, are required for individuals with a high priority score and are not required, but are authorized, for individuals with a low priority score. After completing a screening or rescreening, the DOEA is required to place all individuals with a high priority score on the waitlist. The DOEA must maintain contact information for individuals with low priority scores and ADRC personnel must inform individuals with a low priority score of community resources available to assist them and inform them that they may contact the ADRC for a new assessment at any time if they experience a change in circumstances.

**Section 2** amends s. 430.205, F.S., to allow a CCE service provider to dispute a referral from protective investigations of an elderly adult determined to be in need of services or to be the victims of abuse by requesting that the adult protective services program negotiate the referral placement of, and services provided to, the adult. If an agreement cannot be reached with the APS program, the program's recommendation prevails.

**Section 3** establishes an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[23] *Id.*
[24] Section 430.203(7), F.S.
[25] Section 430.205(5)(a), F.S.
[26] Section 430.205(5)(b), F.S.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 1544 requires updates to the database, application, and supporting reports to accommodate the designations of high priority score and low priority score. The DOEA can absorb these updates within existing resources.[27]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

Section 2 of the bill republishes current statutory language requiring vulnerable elderly persons to begin to receive services from the CCE services provider within 72 hours of being referred to the provider by protective investigations. The bill's new language added in that section allows the service provider to dispute such referral, however, it is unclear whether the bill would require this dispute to be resolved within the 72-hour time frame established in current law. The bill may need to be clarified on this point.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.979 and 430.205.

[27] *Supra* note 1.

## IX. Additional Information:

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

**CS by Health Policy on February 4, 2020:**
The CS eliminates provisions of the underlying bill related to exempting the value of life insurance policies from an applicant's assets when applying for Medicaid. The bill also revises language related to placement of individuals on the LTC waitlist to make technical changes.

B. Amendments:

None.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** February 10, 2020

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I respectfully request that **Senate Bill #1544**, relating to Long Term Care, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ben Albritton
Florida Senate, District 26

File signed original with committee office

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

SB 1544
*Bill Number (if applicable)*

Topic Long Term Care

*Amendment Barcode (if applicable)*

Name Dorene Barker

Job Title Associate State Director

Address 215 S. Monroe St., Suite 603
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone 850-228-6387

Email dobarker@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing AARP FL

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/20
*Meeting Date*

1544
*Bill Number (if applicable)*

Topic Long Term Care

*Amendment Barcode (if applicable)*

Name Robert Beck

Job Title PinPoint Results

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*Street*

Phone 850 766 1410

Tallahassee FL 32301
*City* *State* *Zip*

Email Robert@PinPointresults.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida's Area Agencies on Aging

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/25/2020
*Meeting Date*

1544
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Long-Term Care

Name Tanya C. Jackson

Job Title

Address 150 S. Monroe St, Ste. 303
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*City* *State* *Zip*

Phone 850-445-0107

Email TanyaJ@InsightResults.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing 1199 SEIU Healthcare Workers

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

**By** the Committee on Health Policy; and Senator Albritton

588-03089-20 20201544c1

A bill to be entitled

An act relating to long-term care; amending s. 409.979, F.S.; requiring aging resource center personnel to annually rescreen certain individuals with high priority scores for purposes of the statewide wait list for enrollment for home and community-based services; authorizing such personnel to administer rescreening for certain individuals with low priority scores; requiring the Department of Elderly Affairs to maintain contact information for individuals with low priority scores for rescreening purposes; requiring aging resource center personnel to inform such individuals of community resources; amending s. 430.205, F.S.; authorizing community-care-for-the-elderly services providers to dispute certain referrals; providing that a referral decision by adult protective service prevails; providing an effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (3) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(3) WAIT LIST, RELEASE, AND OFFER PROCESS.—The Department of Elderly Affairs shall maintain a statewide wait list for enrollment for home and community-based services through the long-term care managed care program.

(a) The Department of Elderly Affairs shall prioritize







588-03089-20 20201544c1

individuals for potential enrollment for home and community-based services through the long-term care managed care program using a frailty-based screening tool that results in a priority score. The priority score is used to set an order for releasing individuals from the wait list for potential enrollment in the long-term care managed care program. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the wait list shall receive priority for release.

1. Pursuant to s. 430.2053, aging resource center personnel certified by the Department of Elderly Affairs shall perform the screening for each individual requesting enrollment for home and community-based services through the long-term care managed care program. The Department of Elderly Affairs shall request that the individual or the individual's authorized representative provide alternate contact names and contact information.

2. The individual requesting the long-term care services, or the individual's authorized representative, must participate in an initial screening or rescreening for placement on the wait list. The screening or rescreening must be completed in its entirety before placement on the wait list.

3. Pursuant to s. 430.2053, aging resource center personnel shall administer rescreening annually or upon notification of a significant change in an individual's circumstances for an individual with a high priority score. Aging resource center personnel may administer rescreening annually or upon notification of a significant change in an individual's circumstances for an individual with a low priority score.

4. The Department of Elderly Affairs shall adopt by rule a

screening tool that generates the priority score, and shall make publicly available on its website the specific methodology used to calculate an individual's priority score.

(b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the individual or the individual's authorized representative that the individual has been placed on the wait list, unless the individual has a low priority score. The Department of Elderly Affairs must maintain contact information for each individual with a low priority score for purposes of any future rescreening. Aging resource center personnel shall inform individuals with low priority scores of community resources available to assist them and inform them that they may contact the aging resource center for a new assessment at any time if they experience a change in circumstances.

Section 2. Paragraph (a) of subsection (5) of section 430.205, Florida Statutes, is amended to read:

430.205 Community care service system.—

(5) Any person who has been classified as a functionally impaired elderly person is eligible to receive community-care-for-the-elderly core services.

(a) Those elderly persons who are determined by protective investigations to be vulnerable adults in need of services, pursuant to s. 415.104(3)(b), or to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm and are referred by the adult protective services program, shall be given primary consideration for receiving community-care-for-the-elderly services. As used in this paragraph, "primary consideration" means that an assessment





and services must commence within 72 hours after referral to the department or as established in accordance with department contracts by local protocols developed between department service providers and the adult protective services program. Regardless, a community-care-for-the-elderly services provider may dispute a referral under this paragraph by requesting that adult protective services negotiate the referral placement of, and the services to be provided to, a vulnerable adult or victim of abuse, neglect, or exploitation. If an agreement cannot be reached with adult protective services for modification of the referral decision, the determination by adult protective services shall prevail.

Section 3. This act shall take effect July 1, 2020.

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 1726 (233364) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Bean |
| SUBJECT: | Agency for Health Care Administration |
| DATE: | February 26, 2020 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Kibbey | Brown | HP | **Fav/CS** |
| 2. | McKnight | Kidd | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/CS/SB 1726 addresses statutory duties and responsibilities of the Agency for Health Care Administration (AHCA) relating to the regulation of health care facilities and providers. The bill:

- Modifies annual birth center reporting to the AHCA.
- Removes outdated language relating to certificate of need, to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee.
- Reinstates the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries.
- Extends the current rural hospital designation to 2025 (set to expire June 30, 2021).
- Repeals an unenforceable annual assessment ruled unconstitutional.
- Removes provisions requiring fixed inspection time frames for nursing home facilities, hospices, assisted living facilities, and adult family care homes.
- Revises definitions and licensure requirements related to home health agencies.
- Creates an exemption to health care clinic licensure for federally certified providers.
- Removes the ability of a health care clinic to submit a surety bond instead of submitting certain documents as proof of financial ability to operate to satisfy initial licensure requirements.
- Creates risked-based licensure inspections for nurse registries, home medical equipment providers, and health care clinics to provide the AHCA the flexibility to inspect high-performing providers less frequently than poor performers.

- Authorizes the AHCA to adopt rules to waive a routine inspection, to waive an inspection for relicensure, or to allow an extended period between inspections for any provider type based upon specified factors.
- Authorizes the AHCA to issue a provisional license to all provider types.
- Revises requirements for the approval of comprehensive emergency management plans for newly-licensed facilities.
- Authorizes the AHCA to collect all legal fees incurred while defending a Medicaid case if the AHCA prevails.
- Clarifies the AHCA's authority to conduct retrospective reviews of Medicaid hospital inpatient claims and recover overpayments.
- Revises background screening regulations for health care provider staff.
- Removes class III psychiatric facilities from the diagnosis-related group (DRG) payment methodology.
- Removes the nursing home unit cost rate freeze.
- Aligns the state Medicaid anti-kickback law with the federal anti-kickback law.
- Requires the AHCA to extend the term of contracts awarded to Statewide Medicaid Managed Care plans (the Managed Medical Assistance Program, Long-term Care Program, and Dental Program) from five- to six-years, effectively extending current contracts through December 31, 2024.
- Requires the Florida Center for Health Information and Transparency to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels.
- Expands the list of shoppable health care services that qualify for a shared savings incentive for patients to include services with the most significant price variation. Allows cash and cash equivalent incentives in shared savings incentives.
- Repeals multiphasic health testing center licensure.
- Replaces several legislatively mandated reports with online publications and repeals obsolete reports.

The bill has an indeterminate yet likely insignificant fiscal impact to the AHCA. See Section V.

The bill takes effect on July 1, 2020, except as otherwise expressly provided in the bill and except for the effective date section, which takes effect upon this bill becoming a law.

## II. Present Situation:

The Agency for Health Care Administration (AHCA) is created in s. 20.42, F.S. It is the chief health policy and planning entity for the state and is responsible for, among other things, health facility licensure, inspection, and regulatory enforcement. It licenses or certifies and regulates 40 different types of health care providers, including hospitals, nursing homes, assisted living facilities, and home health agencies. In total, the AHCA licenses, certifies, regulates or provides exemptions for more than 48,000 providers.[1]

[1] *See* the Agency for Health Care Administration, Division of Health Quality Assurance http://ahca.myflorida.com/MCHQ/index.shtml (last visited Jan. 23, 2020).

Generally applicable provisions of health care provider licensure are addressed in the Health Care Licensing Procedures Act in part II of ch. 408, F.S. Additional chapters or sections in the Florida Statutes provide specific licensure or regulatory requirements pertaining to health care providers in this state.[2]

Due to the many diverse issues within the bill, pertinent background information is provided within the effect of proposed changes for the reader's convenience.

## III. Effect of Proposed Changes:

### Birth Center Reporting

**Section 1** amends s. 383.327, F.S. Birth centers are required under current law to immediately report each maternal death, newborn death, and stillbirth to the medical examiner. Changes to subsection (2) of this section require birth centers to immediately report this information to the AHCA as well. Changes to subsection (4) of this section remove the requirement that birth centers submit a report to the AHCA annually and instead require reports to be submitted at a frequency adopted by the AHCA in rule. These changes could enable the AHCA to have the most current information to review during the inspection of a birth center.

### Hospital Licensure and Registries

Chapter No. 2019-136, L.O.F. (enacted by the Legislature in 2019 as CS/HB 21) removes certificate of need (CON) review requirements for hospitals over time, with the final change occurring on July 1, 2021. The Legislature also repealed s. 408.0361(5)(b), F.S., that required hospitals with adult cardiovascular programs to participate in clinical outcome reporting systems.[3,4]

**Section 2** amends s. 395.003(4), F.S., to remove the requirement that all beds not covered by any specialty-bed-need methodology be specified as general beds on the face of the hospital's license. If this subsection is not updated to reflect recent changes to CON requirements, specialty hospital beds such as neonatal intensive care beds will incorrectly be reported as general acute care beds on the face of the hospital's license.

**Section 3** amends s. 395.1055, F.S., to reinstate the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries. Adult diagnostic cardiac catheterization programs and Level I or Level II cardiovascular programs must participate in either the American college of Cardiology or American Heart Association registry to document quality improvement plans. Hospitals licensed for Level II adult cardiovascular services must participate in the Society for Thoracic Surgeons clinical outcome reporting systems.[5]

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[2] *See* s. 408.802, F.S., for the health care provider types and applicable licensure statutes.
[3] Chapter No. 2019-136, Laws of Fla.
[4] Florida House of Representatives, *CS/HB 21 Final Bill Analysis* (June 26, 2019), *available at* https://www.flsenate.gov/Session/Bill/2019/21/Analyses/h0021z1.HMR.PDF (last visited Feb. 25, 2020).
[5] Agency for Health Care Administration, *Analysis for Amendments to SB 1726* (February 25, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

**Rural Hospitals**

There are currently 28 hospitals in Florida that are recognized as meeting the definition of "rural hospital" as defined in 395.602(2)(b), F.S.[6] The hospital must have 100 or fewer beds and an emergency room and meet one of the six additional criteria in order to be considered a rural hospital. Several of the criteria are based on the population density of up to 100 persons per square mile as well as distance from another acute care hospital. Hospitals licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year are designated as a rural hospital through June 30, 2021.[7]

**Section 4** amends s.395.602, F.S., to extend the current rural hospital designation through June 30, 2025.

**Repeal of an Unenforceable Assessment**

**Section 5** repeals s. 395.7015, F.S., which imposes an annual assessment on ambulatory surgical centers and certain diagnostic-imaging centers that are freestanding outpatient facilities. These assessments were ruled to be unconstitutional in 2002, and are no longer collected. [8]

**Section 6** amends s. 395.7016, F.S., to conform a cross-reference to this section.

**Licensure Inspections for Nursing Home Facilities, Hospices, Assisted Living Facilities, and Adult Day Care Centers**

Uniform licensing requirements in s. 408.811, F.S., require the biennial inspection of health care facilities unless otherwise specified in statute or in rule. Sections of the bill listed below remove the frequency required in statute for nursing home facilities, hospices, assisted living facilities, and adult day care centers.

Federal law currently requires the AHCA to inspect a nursing home facility, at a minimum, every 15 months.[9] Section 400.19, F.S., also requires the AHCA to inspect a nursing home facility every 15 months. The AHCA is required to inspect a nursing home facility every six months for two years if the facility has been cited for a class I deficiency, has been cited for two or more

[6] Section 395.602(2)(b), F.S., defines "rural hospital" as an acute care hospital licensed under ch. 395, F.S., having 100 or fewer licensed beds and an emergency room, which is: the sole provider within a county with a population density of up to 100 persons per square mile; an acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; a hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile; a hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds; a hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or a hospital designated as a critical access hospital, as defined in s. 408.07, F.S.

[7] *Supra* note 5.

[8] *Agency for Health Care Admin. v. Hameroff*, 816 So. 2d 1145, 1149-1150 (Fla. 1st DCA 2002).

[9] 42 C.F.R. s. 488.308(a).

class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a six-month period, each resulting in at least one class I or class II deficiency. Those nursing home facilities are required to pay a $6,000 fine for the two additional inspections.

**Section 7** amends s. 400.19, F.S., to remove the 15-month inspection requirement from state law and instead requires the AHCA to conduct periodic unannounced licensure inspections. This provision would require the AHCA to conduct licensure surveys every six months for a facility that has been cited for a class I or two or more class II deficiencies within a 60-day period until the facility has two consecutive licensure surveys without a class I or class II deficiency citation. The AHCA maintains current statutory authority to assess a fine of $6,000 for the additional six month licensure survey.

**Section 14** amends s. 400.605(3), F.S., to remove the requirement that the AHCA must inspect hospices annually or biennially for hospices having a three-year record of substantial compliance and instead requires the AHCA to conduct inspections and investigations of hospices as necessary to determine compliance.

**Sections 48 and 49** amend ss. 429.35(2) and 429.905(2), F.S., to remove the requirement (and related provisions) that the AHCA inspect assisted living facilities biennially.

**Section 50** amends s. 429.929, F.S., to remove a provision authorizing the AHCA to conduct an abbreviated biennial inspection of an adult day care center that has a record of good performance. It also removes a provision requiring the AHCA to conduct a full inspection of an adult day care center that has had one or more confirmed complaints.

**Home Health Agencies**

Section 400.462(12), F.S., defines the term "home health agency" as an organization that provides home health services and staffing services. An organization that provides only home health services does not meet the definition of a home health agency.

Subsection (30) of that section defines the term "staffing services" as services provided to a health care facility, school, or other business entity on a temporary or school-year basis pursuant to a written contract by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency or who are registered with a licensed nurse registry.

Subsection (14) of that section defines "home health services" as the following services that are provided by an organization:

- Nursing care.
- Physical, occupational, respiratory, or speech therapy.
- Home health aide services.
- Dietetics and nutrition practice and nutrition counseling.
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.

Subsection (22) of that section defines the term "organization" as a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.

**Section 8** amends s. 400.462, F.S., to revise the definitions of the terms "home health agency," "home health services," "home infusion therapy provider," and "nurse registry" and deletes the definition of the term "organization."

- "Home health agency" is redefined to mean a person that provides one or more home health services, as opposed to an organization that provides home health services (plural) and staffing services as under current law. As a result, the word "person" (as defined in s.1.01(3), F.S.) includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations..
- "Home infusion therapy provider" is redefined to pertain to "a person," as opposed to "an organization" that meets the definition's criteria.
- "Home health services" is redefined to conform to elimination of the term "organization" in other definitions, and the definition of "organization" itself is eliminated since that term becomes obsolete under the bill for this section of statute.

The current definition of organization only refers to entities and does not include individual persons, which creates a potential loophole for an individual person to employ health care personnel for the provision of home health services without having to obtain a license.[10] Under the bill, such an individual must obtain a license if they are not currently exempt from licensure as a home health agency pursuant to s. 400.464(5), F.S.

The AHCA has interpreted the provision of home health services to be an activity that requires licensure as a home health agency and does not believe changes to this section will impact services that require licensure.[11] However, it is unclear if there are unlicensed individuals that employ or may seek to employ health care personnel for the provision of home health services that would be required to obtain a license under the bill and not qualify for licensure exemption. Under the bill, such an individual would be subject to the provisions of s. 400.471(5), F.S., which requires an applicant or licensee for home health agency licensure to pay a fee for each submitted application. The fee must be established by the AHCA in rule at an amount sufficient to cover the AHCA's costs in carrying out its responsibilities, not to exceed $2,000 per biennium. Under this statutory authority in current law, the AHCA is imposing a $1,705 fee for initial licensure, change of ownership, or licensure renewal.[12] See Sections IV.D. and VI.

[10] Agency for Health Care Administration, *Senate Bill 1726 Agency Analysis* (on file with the Senate Committee on Health Policy).
[11] Email from the Agency for Health Care Administration (February 5, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[12] 59A-8.003, F.A.C.

**Section 9** amends s. 400.464, F.S., to make conforming changes and to make exemptions from licensure as a home health agency for a person that provides skilled care by health care professionals licensed solely under part I of ch. 464, F.S., (nursing); part I, part III, or part V of ch. 468, F.S., (speech therapy, occupational therapy, or respiratory therapy); or ch. 486, F.S., (physical therapy). Skilled care services are currently defined in s. 400.462(29), F.S. This exemption currently indirectly exists within the definition of "organization" that is being stricken in Section 8 of the bill. The section also clarifies that the exemption does not authorize an individual to perform home health services without the required professional license.

**Section 10** amends s. 400.471(2)(g), F.S., to require applicants for change of ownership or license renewal to provide proof of accreditation and a survey demonstrating compliance with the applicable licensure requirements prior to licensure for the addition of skilled services.

**Sections 11-13** amend ss. 400.492, 400.506, and 400.509, F.S., to conform provisions to changes made to the definitions section for part III of ch. 400, F.S., in Section 8 of the bill.

**AHCA Reporting Requirements**

**Section 15** amends s. 400.60501, F.S., to delete a requirement that the AHCA develop an annual report that analyzes and evaluates the information collected under the Health Care Clinic Act. It also removes an obsolete date. Hospice outcome and quality information is currently published on FloridaHealthFinder.gov.

**Section 22** amends s. 408.0611, F.S., to require the AHCA to report on its website information on the implementation of electronic prescribing rather than issuing an annual report to the Governor and the Legislature. The AHCA already updates this information quarterly on the ePrescribing dashboard of its website.[13]

**Section 23** amends s. 408.062, F.S., to require the AHCA to report on its website information relating to the use of hospital emergency department services by patient acuity level and on health care quality measures rather than issuing an annual status report to the Governor and the Legislature. Most information that is required to be in the report is available on FloridaHealthFinder.gov.

**Section 24** amends s. 408.063, F.S., to remove the requirement that the AHCA publish an annual comprehensive report of state health expenditures. This report currently identifies the contribution of health care dollars made by all payors and the dollars expended by the type of health care service. The AHCA indicates that this report has little value because of a three-year delay in reporting information.[14]

**Section 35** amends s. 408.909, F.S., to delete a provision requiring the AHCA to evaluate and provide an annual assessment to the Governor and the Legislature relating to the Health Flex Plan. The Health Flex Plan program was a pilot program established to benefit low-income families who were not eligible for public assistance programs and not covered by private

[13] Agency for Health Care Administration, *ePrescribing Clearinghouse*. https://ahca.myflorida.com/SCHS/ePrescribing/metrics.shtml (last visited Jan. 24, 2020).
[14] *Supra* note 10.

insurance.[15] There were initially only three plans in limited service areas available for consumers. There is currently only one remaining Health Flex Plan with fewer than 300 members.[16]

**Section 36** amends s. 408.9091, F.S., to remove the requirement that the AHCA and the Office of Insurance Regulation of the Financial Services Commission jointly submit an annual report to the Governor and the Legislature relating to the implementation of the Cover Florida Health Care Access Program. There are currently no plans participating in the Cover Florida Health Care Access Program.[17] The last participating health plan terminated its Cover Florida policies in January of 2015.[18]

**Section 42** amends s. 409.913, F.S., to move the Medicaid Program Integrity Annual Report due date from January 1, which is a national holiday, to January 15. Other changes made to this section of statute are discussed below.

**Section 47** amends s. 429.19(9), F.S., to remove the requirement that the AHCA develop and disseminate a list of all assisted living facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The AHCA is required by s. 429.55(2), F.S., to create an accessible website containing this information and has done so with FloridaHealthFinder.gov.[19]

**Health Care Clinics**

**Section 16** amends s. 400.9905, F.S., to provide exemptions from health care clinic licensure for Medicaid providers, for certain federally certified providers, for entities under common ownership by a mutual insurance holding company, and for certain entities that are owned by an entity that is a behavioral health service provider.

There are currently over 14 exemptions listed in the health care clinic licensure laws.[20] Most of these exemptions are for health care providers that are already licensed and regulated by the AHCA, an establishment or profession regulated by the Department of Health (DOH), a provider that is federally certified, a non-profit entity, or an entity with substantial financial commitment.

Comprehensive outpatient rehabilitation facilities (42 C.F.R. part 485, subpart B), outpatient physical therapy and speech-language pathology providers (42 C.F.R. part 485, subpart H), end stage renal diseases (42 C.F.R. part 494), and clinical laboratories are all federally certified providers that are regulated by the AHCA. These providers qualify for an exemption from health care clinic licensure.

Changes made in this section of the bill provide exemptions for other federally certified providers that are regulated by the AHCA, including community mental health center-partial

[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*

hospitalization programs (42 C.F.R. part 485, subpart J), portable X-ray providers (42 C.F.R. part 486, subpart C) and rural health care clinics (42 C.F.R. part 491, subpart A).

The Fiscal Year 2019-2020 Implementing Bill created two additional exemptions from clinic licensure for entities owned by an insurance holding company with over $1 billion in annual sales and entities owned by a behavioral health provider in at least five states with $90 million in annual revenues from behavioral health.[21] These exemptions are in effect until June 30, 2020.[22] Language in this section of CS/SB 1726 provides that those two exemptions will be permanent.

Providers that meet the definition of health care clinic who do not qualify for an exemption must obtain a license, and providers that participate in Medicaid must meet all requirements in applicable state laws. Medicaid recently initiated rule-making to add licensure as a health care clinic when required by law to be a pre-requisite to enrollment as a Medicaid provider. Over 20,000 providers have been identified as possibly requiring a health care clinic license to remain in Medicaid, though some will likely qualify for an exemption.[23] An estimated 13,000 may require licensure to meet Medicaid requirements by December 2020.[24] The AHCA asked for 13 positions to support this workload through a legislative budget request.[25]

**Section 17** amends s. 400.991(3)(c), F.S., to remove the option for a health care clinic to file a surety bond of at least $500,000 as an alternative to submitting proof of financial ability to operate with its application for initial licensure or a change in ownership. No health care clinics have submitted the surety bond in lieu of proof of financial ability to operate.[26]

**Section 18** amends s. 400.9935(1)(i), F.S., to authorize a health care clinic's schedule of charges to group services by price level. This section of the bill revises the requirement that the schedule must be posted in the reception area of the urgent care center of a clinic to only require posting in the reception area of a clinic that meets the definition of an "urgent care center" as defined in s. 395.002(29)(b), F.S.

**Deleting a Reference to a Specific Data Collection Rule**

**Section 21** amends s. 408.061, F.S., to remove a reference to a repealed Rule 59E-7.012, F.A.C. Rules 59E-7.011-7.020, F.A.C., were repealed and replaced with Rules 59E-7.021-7.030, F.A.C.

**Low-Risk Providers and Licensure Inspections**

**Section 26** amends s. 408.803, F.S., to define the term "low-risk provider" as nurse registries, home medical equipment providers, and health care clinics. The AHCA has determined these specific provider types to be low-risk with infrequently cited deficiencies.[27] This section of the bill also conforms a provision to changes made in Section 49 of the bill.

[21] Chapter No. 2019-116, s. 38, Laws of Fla.
[22] *Id.*
[23] *Supra* note 10.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

**Section 27** amends s. 408.806, F.S., to exempt low-risk providers from an initial licensure inspection as required under s. 408.811, F.S.

**Section 30** amends s. 408.811, F.S., to authorize the AHCA to exempt a low-risk provider from licensure inspections if the provider or controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory actions, as defined by the AHCA in rule. Under the bill, the AHCA is required to conduct unannounced licensure inspections for at least 10 percent of exempt low-risk providers.

The bill also authorizes the AHCA to adopt rules to waive routine inspections and inspections for relicensure or to allow for an extended period between relicensure inspections for specific providers based upon:

- A favorable regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory measures.
- Outcome measures that demonstrate quality performance.
- Successful participation in a recognized quality assurance program.
- Accreditation status.
- Other measures reflective of quality and safety.
- The length of time between inspections.

With these changes, a provider will not necessarily have to meet any specific statutory requirement for the AHCA to waive the routine inspection. The AHCA's rules must base the decision to grant a waiver upon one or all of the factors listed above.

As it does with low-risk providers, the bill also requires the AHCA to conduct unannounced licensure inspections for at least 10 percent of providers that qualify for a waiver or extended period between licensure inspections.

**Provisional Licenses for Health Care Facilities**

Section 408.808(2), F.S., currently authorizes the AHCA to issue a provisional license for health care providers regulated under ch. 408, F.S., to a provider applying for a change of ownership or to a provider that is in litigation with the AHCA regarding the denial or revocation of its license.

Section 429.11(6), F.S., currently authorizes the AHCA to issue a provisional license for an assisted living facility when the provider is making an initial application for licensure.

**Section 28** amends s. 408.808(2), F.S., to authorize the AHCA to issue a provisional license to an applicant for initial licensure as a health care provider under ch. 408, F.S., in addition to applicants for a change of ownership.

**Section 46** amends s. 429.11(6), F.S., to remove provisions authorizing the AHCA to issue a provisional license to an assisted living facility because the AHCA would be authorized to issue a provisional licensed to an assisted living facility through the bill's changes to s. 408.808, F.S.

**Background Screening Requirements for Health Care Providers and Employees**

Seven state agencies participate in the Care Providers Background Screening Clearinghouse authorized in ch. 435, F.S. **Section 29** amends s. 408.809(2), F.S., to remove an obsolete provision relating to agencies that were once in the process of joining the Clearinghouse. All seven agencies are now fully implemented in the Clearinghouse.

**Section 29** also amends s. 408.809(5), F.S., to remove an expired provision that allowed for an employee who becomes disqualified from employment because of legislation that created a new disqualifying offense, to continue to work pending the employee's request for an exemption from disqualification. That authority expired in 2014.

Federal regulations require state Medicaid programs to conduct criminal background checks including fingerprinting when required to do so under state law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of providers.[28] State Medicaid programs are also required to conduct a criminal background check and require the submission of a set of fingerprints in accordance with 42 C.F.R. s. 455.434 for providers designated as a high categorical risk.[29] The AHCA designates high categorical risk providers in the Florida Medicaid Provider Enrollment Policy handbook incorporated in Rule 59G-1.060, F.A.C.[30]

**Section 39** amends s. 409.907, F.S., to revise background screening requirements for Medicaid providers and codify federal requirements. This section of the bill requires a level 2 background screening to be conducted through the AHCA for certain persons who render services to Medicaid recipients, who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient. This change does not impose additional screening requirements on any providers licensed under part II of ch. 408, F.S. See Sections IV.D. and VI. Drivers providing transportation to Medicaid recipients through a transportation broker or a transportation network company are required to undergo a level 1 background screening through the Florida Department of Law Enforcement or, for Transportation Network Companies, an AHCA-approved equivalent background screening. The AHCA does not require level 2 screening for transportation drivers.[31] **Section 39** clarifies that these drivers are required to undergo only the level 1 background (or equivalent) screening, not the required level 2 background screening.

**Comprehensive Emergency Management Plans**

Different provider types are subject to different comprehensive emergency management plan requirements in their authorizing statutes. Assisted living facilities are required to get plan

[28] 42 CFR s. 455.434
[29] 42 CFR s. 455.450
[30] Providers and suppliers designated as "high" categorical risk include: behavior analysis practitioners, mental health targeted case management providers, physical therapists, physician groups owned by non-physicians, prospective (newly enrolling) home health agencies and other home health service providers, prospective (newly enrolling) durable medical equipment, and prosthetics, orthotics, and supplies suppliers. Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Policy* (December 2019), *available at* https://ahca.myflorida.com/medicaid/review/General/59G-1.060.pdf (last visited Feb. 25, 2020).
[31] *Supra* note 5.

approval by local emergency management officials before they may be licensed. The AHCA indicates that some local jurisdictions refuse to review a plan until the provider is licensed.[32] This makes it impossible for providers within those jurisdictions to become lawfully licensed.

**Section 32** amends s. 408.821, F.S., to require providers that are required by authorizing statutes and the AHCA rule to have a comprehensive emergency management plan to:

- Submit the plan to the local emergency management agency, county health department, or the DOH within 30 days after initial licensure and change of ownership, and notify the AHCA within 30 days after submission of the plan.
- Submit the plan to the local emergency management agency, county health department, or the DOH annually and within 30 days after any significant modification, as defined by the AHCA rule, to a previously approved plan.
- Respond to the local emergency management agency, county health department, or the DOH with necessary plan revisions within 30 days after notification that plan revisions are required.
- Notify the AHCA within 30 days after approval of its plan by the local emergency management agency, county health department, or the DOH.

These changes establish consistent timeframes for the submission and review of comprehensive emergency management plans among provider types. This change allows for the licensure of a facility before its comprehensive emergency management plan is approved.

**The Medicaid Program's Retrospective Review of Hospital Inpatient Admissions**

The AHCA performs routine pre- and post-payment claim reviews to determine the appropriateness of Medicaid provider reimbursement.[33]

**Section 37** amends s. 409.905(5), F.S., to clarify that a specific provision in paragraph (a) of that subsection may not be construed to prevent the AHCA from conducting retrospective reviews in its efforts to combat Medicaid fraud and abuse and to recoup overpayments in the Medicaid Program.

The provision of current law that the bill seeks to clarify was enacted under ch. 2001-104, L.O.F. Before the enactment of that law, the AHCA had statutory authority to prior authorize inpatient hospital admissions for Medicaid patients with psychiatric and substance abuse diagnoses. However, there was no specific authority for the AHCA to prior authorize inpatient hospital admissions for any other diagnoses.[34]

In lieu of prior authorization of inpatient hospital admissions for general acute care Medicaid services, the Medicaid Program was under contract in 2001 with a peer review organization for retrospective review of such admissions. If those retrospective reviews encountered inpatient admissions that should have been denied or inpatient services that were provided outside of

[32] *Id.*
[33] *Id.*
[34] *See* Chapter 2001-104, L.O.F., *available at* http://laws.flrules.org/files/Ch_2001-104.pdf (last visited Jan. 30, 2020).

medical necessity, the AHCA would require the hospital to repay the Medicaid program for the associated costs.[35]

Under ch. 2001-104, L.O.F., the Legislature amended s. 409.905(5)(a), F.S., to give the Medicaid Program authority to prior authorize nonemergency hospital inpatient admissions for individuals 21 years of age or older. The statute was also amended to allow Medicaid to require authorization of emergency and urgent-care admissions within 24 hours after Medicaid patients were admitted under such conditions.

Along with this new authority, the statute was further amended in 2001, in the same paragraph, to require the AHCA, upon implementing the prior authorization program for hospital inpatient services, to discontinue the Medicaid Program's hospital retrospective review efforts. CS/SB 1726 specifically addresses this latter provision of the 2001 law to clarify that the required discontinuation of the Medicaid Program's preexisting retrospective review program, which was being conducted in 2001 in lieu of prior authorization, may not be construed to prevent the AHCA's Office of Medicaid Program Integrity (MPI)[36] from conducting retrospective reviews under s. 409.913, F.S.

***The Office of Medicaid Program Integrity***

Section 409.913, F.S., is entitled, "Oversight of the integrity of the Medicaid program." This section of statute requires the AHCA to:

- Operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate;
- Conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate; and
- Conduct reviews of provider exceptions to peer group norms and, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

Section 409.913, F.S., further provides that a Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the AHCA. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack of medical necessity.

[35] Senate Committee on Health Care, *Senate Staff Analysis and Economic Impact Statement for CS/SB 792* (April 5, 2001), *available at* http://www.flsenate.gov/Session/Bill/2001/792/Analyses/20010792SHC_2001s0792.hc.pdf (last visited Jan. 30, 2020).

[36] *See* the Office of Medicaid Program Integrity's web page at https://ahca.myflorida.com/MCHQ/MPI/ (last visited Jan. 30, 2020).

MPI and the Medicaid Fraud Control Unit of the Department of Legal Affairs must submit a joint report to the Legislature each January, documenting the results of their work to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report for State Fiscal Year 2018-2019 indicates that overpayments of approximately $32.7 million were identified in that fiscal year, with approximately $13.4 million in accounts-receivable collections and reversals. MPI also prevented approximately $385.2 million in overpayments from occurring during the fiscal year, according to the 2018-2019 report.[37]

The bill clarifies that the Legislature's direction to the AHCA in 2001 to discontinue the Medicaid Program's hospital retrospective review efforts upon implementing its newly-granted authority to prior authorize Medicaid hospital inpatient admissions, may not be construed to prevent MPI from conducting retrospective reviews under s. 409.913, F.S. This provision of the bill takes effect upon becoming law.[38]

**Section 38** provides that it is the intent of the Legislature that the amendment to s. 409.905(5)(a), F.S., in Section 37 of the bill, is intended to confirm and clarify existing law. This section takes effect upon becoming a law.

**Reimbursement of Medicaid Providers**

Class III psychiatric facilities are excluded in statute from the diagnosis related group (DRG) payment methodology. Federal law prohibits state Medicaid programs from receiving federal matching funds for services provided by facilities described in 42 CFR 435.1010 as an institution for mental diseases[39] (IMDs) under the fee-for-service program and therefore, the AHCA has not established the alternative methodology currently allowed under s. 409.908, F.S. However, in Medicaid managed care programs, states have slightly more flexibility; health plans may pay for services in an IMD in lieu of more costly services. For example, Florida Medicaid cannot pay for services in a crisis stabilization unit under the fee-for-service program. However, Medicaid managed care contracts allow health plans to pay for services in a crisis stabilization unit for a plan enrollee, as crisis stabilization units provide a less costly service equivalent to inpatient psychiatric hospitalization.[40]

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[37] The Agency for Health Care Administration and the Department of Legal Affairs, *Florida's Efforts to Control Medicaid Fraud & Abuse: Fiscal Year 2018-2019* (December 30, 2019) *available at* https://ahca.myflorida.com/MCHQ/MPI/docs/FraudReports/FraudReport2018-19.pdf (last visited Jan. 30, 2020).

[38] In February 2019, Florida's First District Court of Appeal construed the discontinuation provision in s. 409.905(5)(a), F.S., to mean that the AHCA is "barred from conducting a retrospective review of prior authorization claims" under s. 409.913, F.S., or any other existing statutory authority. See *Lee Memorial Health System Gulf Coast Medical Center v. State of Florida, Agency for Health Care Administration*, 272 So.3d 431 (Fla. 1st DCA 2019). The AHCA reports that, under this ruling: (1) The AHCA is at risk of being required to repay overpayments that have already been recouped by MPI from hospitals, and (2) MPI is prohibited from conducting any hospital retrospective audits, except those relating to suspected fraud or abuse. Email from the Agency for Health Care Administration to the Senate Committee on Healthy Policy (January 30, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services). See Section V.C.

[39] 42 CFR 435.1010 defines an "institution for mental diseases" as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

[40] *Supra* note 5.

During the 2008 Session, the Legislature amended s. 409.908, F.S., to implement a two-year unit cost rate freeze effective July 1, 2009, for nursing facilities, hospitals, county health departments, intermediate care facilities for the developmentally disabled, and prepaid health plans.[41] The unit cost rate freeze was set to expire July 1, 2011, however, during the 2011 Session, the Legislature repealed the sunset date, capped unit costs at July 1, 2011 rates, and established reimbursement rates would be as provided in the General Appropriations Act. In effect, automatic annual Medicaid increase payments to nursing homes were capped at 2011 levels.[42] In Fiscal Years 2018-2019 and 2019-2020, the Implementing Bill[43,44] removed the unit cost rate freeze for one year.

**Section 40 and 41** amend s. 409.908, F.S., to remove the nursing home unit cost rate freeze and remove class III psychiatric facilities from the DRG payment methodology, thereby eliminating the AHCA's authority to establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for class III psychiatric hospitals.

**Legal Fees in Medicaid Program Integrity Cases**

**Section 42** amends s. 409.913, F.S., to authorize the AHCA to recover legal fees in Medicaid Program Integrity and licensure cases. The AHCA has indicated that it spends significant funds defending Medicaid overpayment cases. The Division of Administrative Hearings (DOAH) ruled that s. 409.913(23)(a), F.S., does not authorize the AHCA to recover full legal fees on Medicaid Program Integrity legal cases.[45] The specific ruling came in the DOAH case number 18-5986F involving Covenant Hospice.[46] The case had an overpayment of $637,973.10 and sanction of $127,594.62. As of February 7, 2019, the AHCA was seeking to recover fees in the amount of $330,186.14 and costs in the amount of $14,466.52 as of February 7, 2019.[47] Currently, the AHCA only has the ability to collect the "costs" of $14,466.52.[48]

**Multiphasic Health Testing Centers**

Multiphasic health testing centers, regulated under part I of ch. 483, F.S., are facilities where, in addition to taking specimens from the human body for delivery to registered clinical laboratories for analysis, certain measurements such as height and weight determinations, blood pressure determinations, limited audio and visual tests, and electrocardiograms are also made. These additional services are not required to be provided by licensed personnel but can be provided by a medical assistant that is certified or registered through a national organization. These clinics would also fall under the definition of a health care clinic in part X of ch. 400, F.S., but are exempt since they are already regulated by the AHCA.

[41] Chapter 2008-143, s. 5, Laws of Fla.
[42] Chapter 2011-61, s. 4, Laws of Fla.
[43] Chapter 2018-10, s. 18-19
[44] Chapter 2019-116, s. 18-19
[45] *Agency for Health Care Administration v. Covenant Hospice, Inc.,* Case No.18-5986F (Fla. DOAH 2018).
[46] *Id.*
[47] *Id.*
[48] *Id.*

**Section 54** repeals part I of ch. 483, F.S., relating to multiphasic health testing centers, which thereby repeals the requirements for and the licensing of multiphasic health testing centers as a provider type. Current multiphasic health testing centers would need to become licensed as health care clinics, in accordance with part X of ch. 400, F.S., unless they otherwise qualify for an exemption from health care clinic licensure.

As of January 21, 2020, there were 187 multiphasic health testing centers licensed in Florida. Of these, 69 were owned and operated by Laboratory Corporation of America and 111 were owned and operated by Quest Diagnostics, including one out-of-state center.[49] Both Laboratory Corporation of America and Quest Diagnostics also own and operate several clinical laboratories throughout the state that are regulated under the federal Clinical Laboratory Improvement Amendments (CLIA).[50] The remaining seven multiphasic health testing centers are owned by Professional Health Examiners, Inc.[51] Services are provided by licensed personnel under the direction of a medical director, and the company does not bill insurance and thus would also be exempt from health care clinic licensure as would those centers owned and operated by clinical laboratories regulated under the federal CLIA.[52]

Under current law, the AHCA assesses multiphasic health testing centers with a biennial licensure fee of $652.64 and a biennial health care assessment fee of $300 on multiphasic health testing centers. The AHCA collects an estimated $89,071.84 annually ($178,143.68 biennially) from 187 multiphasic health testing centers, roughly half of which renew each year.[53]

Since 2011, the AHCA has imposed only six fines against multiphasic health testing centers.[54] In this timeframe, only 10 complaints were received with none substantiated while 195 deficiencies have been cited since 2011.[55]

**Sections 19, 25, 31, 33, and 34** amend ss. 408.033, 408.802, s. 408.820, 408.831, and 408.832, F.S., to delete references to multiphasic health testing centers or chapter 483, to conform to changes made by Section 54 of the bill, which repeals part I of ch. 483, F.S., relating to multiphasic health testing centers.

**Medicaid Provider Fraud**

New technology and innovative online platforms allow Medicaid patients to access doctor appointment schedules through a web portal hosted by an online service. Health care professionals may contract with such services for a fee. There is concern that this relationship may conflict with anti-kickback provisions in the Florida Medicaid law. These fee-based scheduling services can operate within other health insurance programs such as Medicare, Tricare, and commercial programs. The federal Anti-Kickback Statute[56] prohibits the knowing

[49] *Supra* note 10.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] 42 U.S.C. s. 1320a-7b(b).

and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs. The bill seeks to ensure Florida law mirrors federal law and does not apply a stricter standard than the federal Anti-Kickback Statute.[57]

**Section 43** amends s. 409.920(2)(a), F.S., to align the state Medicaid anti-kickback law with the federal anti-kickback law so that Medicaid recipients can utilize innovations and technological advances to access medical appointments and care, similar to services that are currently used by Medicare, TriCare, and commercial patients.

**Managed Care Plan Contracts**

The AHCA is currently authorized to contract with plans for Statewide Medicaid Managed Care to provide managed medical assistance (MMA), long-term care (LTC) and dental services for a period of 5-years and to extend those contracts to cover any delays during the transition to a new plan following a re-procurement.

The AHCA re-procured these contracts during 2017 and awarded contracts in spring of 2018. Pursuant to statute, those contracts are effective from December of 2018 through December of 2023. While each procurement has presented the AHCA with the opportunity to negotiate significant program gains, included additional benefits for enrollees, enhanced processes to reduce administrative burdens for providers participating in the program, as well as significantly increased quality and performance benchmarks and savings that can be redirected to reward high performing providers, a longer contract period would provide the AHCA with more time to assess program performance as negotiated during the 2017 procurement and allow the collection of additional complete data years that could be considered when the contract is next procured. In addition, a longer contract period would provide the AHCA with additional opportunities to work with stakeholders and the Legislature on substantive program design.

**Sections 44 and 45** amend ss. 409.967 and s. 409.973, F.S., to require the AHCA to establish a 6-year, rather than a 5-year, contract with each Medicaid managed care plan selected through the procurement process. It also requires the AHCA to extend the term of contracts awarded to managed care plans pursuant to the invitation to negotiate published in July 2017, through December 31, 2024, effectively extending the duration of those contracts by one year.

**Health Insurance Benefits**

The Florida Center for Health Information and Transparency (Florida Center), housed within the AHCA, provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.[58] The Florida Center identifies existing health-related data and collects data for use in the information system, including information on health care costs and financing, trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.[59]

[57] *Supra* note 5.
[58] Section 408.05(1), F.S.
[59] Section 408.05(2), F.S.

The Florida Center maintains www.FloridaHealthFinder.gov, which was established by law in 2016[60], to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida.

In 2019, the Legislature enacted the Patient Savings Act[61] (Act), which allows (but does not mandate) health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program (Shared Savings Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. The Act authorizes implementation of these incentive programs for plan years beginning January 1, 2020.

The Act defines a "shared savings incentive" as an optional financial incentive that may be paid to an insured for choosing certain shoppable health care services under a Shared Savings Program. When a patient obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the patient. A patient is entitled to a financial incentive that is no less than 25 percent of the savings that accrue to the insurer as a result of the patient's participation.

The law provides a range of methods by which a Shared Savings Program may financially reward patients who save money by shopping for health care services. Patients may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.[62]

**Sections 20 and 51-53** amend ss. 408.05, 627.6387, 627.6648, and 641.31076, F.S., to increase the range of services defined as "shoppable" for purposes of earning shared savings incentives under a Shared Savings Program. In addition to the specific services outlined in the Patient Savings Act, the bill extends the "shoppable" service designation to those services identified by the Florida Center as having the most significant price variation at statewide and regional levels. The bill also allows a Shared Savings Program to provide cash or a cash-equivalent reward to a program participant who earns a shared savings incentive.

**Cross-references**

**Sections 55-60** amend ss. 20.43, 381.0034, 456.001, 456.057, 456.076, and 456.47, F.S., to conform cross-references to changes made by the bill.

**Effective Date**

**Section 61** provides that except as otherwise expressly provided in the bill and except for this section, which will take effect upon the bill becoming a law, the bill will take effect July 1, 2020.

[60] Chapter 2016-234, Laws of Fla.; *see also* s. 408.05(3), F.S.
[61] Sections 627.6387, 627.6648, and 641.31076, F.S.
[62] Section 627.6387, F.S.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

Article VII, section 19, of the State Constitution requires that a new state tax or fee, as well as an increased state tax or fee, be approved by two-thirds of the membership of each house of the Legislature and be contained in a separate bill that contains no other subject. Article VII, section 19(d)(1), of the State Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."

Currently, an individual could employ health care personnel for the provision of home health services without having to obtain a license. Section 6 of the bill amends s. 400.462, F.S., to require such an individual to obtain a home health agency license by paying the licensure fee required in s. 400.471(5), F.S., unless exempt from licensure pursuant to s. 400.464(5), F.S. This fee is an existing statutory fee that is not being increased; however, the bill expands the scope of licensure for home health agencies which expands the application of the licensure fee (i.e. thereby requiring persons not subject to the fee to pay the fee).

Section 36 of the bill amends s. 409.907(8), F.S, to require a level 2 background screening to be conducted through the AHCA for certain persons who render services to Medicaid recipients, who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient. Accordingly, additional persons will be required to pay the fees for a level 2 background screening, who currently are not subject to that screening.

It is unclear if Article VII, section 19, applies to these provisions of the bill. As such, the State Constitution may require that the fees be passed in a separate bill by a two-thirds vote of the membership of each house of the Legislature.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

### A. Tax/Fee Issues:

Currently, an individual could employ health care personnel for the provision of home health services without having to obtain a license. Section 8 of the bill amends s. 400.462, F.S., to require such an individual to obtain a home health agency license if they are not currently exempt from licensure as a home health agency pursuant to s. 400.464(5), F.S., and pay the licensure fee required in s. 400.471(5), F.S. The AHCA has interpreted the provision of home health services to be an activity that requires licensure as a home health agency and does not believe changes to this section will impact services that require licensure. However, it is unclear if there are unlicensed individuals that employ or may seek to employ health care personnel for the provision of home health services that would be required to obtain a license under the bill and not qualify for licensure exemption. The fee is established by the AHCA in rule at an amount sufficient to cover the AHCA's costs in carrying out its responsibilities, not to exceed $2,000 per biennium. Under the statutory authority in current law, the AHCA is imposing a $1,705 fee for initial licensure, change of ownership, or licensure renewal.[63] The number of individuals impacted by this requirement is indeterminate.

Section 39 of the bill amends s. 409.907(8), F.S. to require level 2 background screenings, in accordance with ch. 435, F.S., for individuals who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient. This does not impose additional screening requirements on any providers licensed under part II of ch. 408. According to the Florida Department of Law Enforcement (FDLE), the cost for a level 2 background screening with five years of Clearinghouse retention is $61.25 ($13.25 for the national criminal record check; $24 for the state criminal record check; and $24 paid up front for five years of state fingerprint Clearinghouse retention).[64] The number of individuals impacted by this requirement is indeterminate.[65]

### B. Private Sector Impact:

Under CS/SB 1726:

- The bill exempts community mental health partial-hospitalization programs, portable x-ray providers, and rural health care clinics from health care clinic licensure. Those providers will no longer be required to pay the $2,000 biennial license renewal fee. The AHCA estimates that approximately 200 providers would qualify for the exemption.
- Low-risk Medicaid providers are exempt from health care clinic licensure. These providers are not currently required to be licensed, but licensure will be required

[63] *Supra* note 10.[64] Email from the Department of Law Enforcement (February 5, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[64] Email from the Department of Law Enforcement (February 5, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[65] *Supra* note 10.

effective July 1, 2020. The AHCA expects 28,291 providers to qualify for the exemption. Providers who qualify for the exemption would not have to pay the $2,000 initial licensure fee.
- The bill repeals licensure for multiphasic health testing centers. As a result, multiphasic health testing centers will no longer be required to pay the biennial license renewal fee of $952.64, although some of these centers will need to pay licensure fees to become licensed as a health care clinic. There are currently 187 multiphasic health testing centers licensed in Florida.
- See Section V.A. for additional fees that may impact individuals not currently required to pay licensure fees now required in s. 400.471.(5), F.S., as amended, and fees associated with a level 2 background screening required in s. 409.907(8), F.S., as amended. The number of individuals impacted by the new requirements is indeterminate.

C. Government Sector Impact:

Under CS/SB 1726:
- Exempting Medicaid providers from health care clinic licensure will result in a cost avoidance. The exemptions created in the bill eliminate the need for the 13 full-time equivalent employees requested in the AHCA's Fiscal Year 2020-2021 legislative budget request to process health care clinic licensure applications.[66]
- The AHCA will be able to conduct retrospective reviews of hospital inpatient claims and recover all overpayments in the Medicaid program. The AHCA lost $13,449,595.12 related to 42 cases that have been or will be closed at zero overpayment due to the court ruling on retrospective hospital audits. The AHCA would likely experience a significant positive fiscal impact from clarification, although the amount recovered from future retrospective reviews is indeterminate.
- The AHCA will be able to recover all legal fees in Medicaid Program Integrity legal cases in which the AHCA prevails. Although the AHCA's tracking system for Medicaid recovery amounts does not distinguish legal fees, the AHCA has incurred over $300,000 in legal fees for a single case.[67] The AHCA would likely experience a significant positive fiscal impact from this, although the amount of legal costs arising from future litigation is indeterminate.
- The bill exempts certain providers from health care clinic licensure and repeals licensure for multiphasic health testing centers. As a result, a loss in annual revenue of $489,071.84 and a commensurate workload reduction will occur from the repeal of multiphasic health testing center licensure ($89,071.84), and the new exemptions from health care clinic licensure for community mental health partial-hospitalization program, portable x-ray providers, and rural health care clinics ($400,000).[68]

The AHCA will also experience a reduction in workload from removing requirements that the AHCA submit various reports to the Governor and the Legislature.

[66] *Id.*
[67] *Id*.
[68] *Id.*

## VI. Technical Deficiencies:

The provisions of section 8 and 39 of the bill, amending s. 400.462 and 409.907, F.S., could result in the application of new fees or assessments.

- Section 8 amends s. 400.462, F.S., to require certain individuals to obtain a home health agency license by paying the licensure fee required in s. 400.471(5), F.S.
- Section 39 amends s. 409.907, F.S., to require level 2 background screenings, in accordance with ch. 435, F.S., for individuals who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient.

See Section IV.D. and Section V.A. A separate fee bill should be considered to address the applicable fees and assessments.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 20.43, 381.0034, 383.327, 395.003, 395.1055, 395.602, 395,7015, 395.7016, 400.19, 400.462, 400.464, 400.471, 400.492, 400.506, 400.509, 400.605, 400.60501, 400.9905, 400.991, 400.9935, 408.033, 408.05, 408.061, 408.0611, 408.062, 408.063, 408.802, 408.803, 408.806, 408.808, 408.809, 408.811, 408.820, 408.821, 408.831, 408.832, 408.909, 408.9091, 409.905, 409.907, 409.908, 409.913, 409.920, 409.967, 409.973, 429.11, 429.19, 429.35, 429.905, 429.929, 456.001, 456.057, 456.076, 456.47, 627.6387, 627.6648, and 641.31076.

This bill repeals the following sections of the Florida Statutes: 395.7015 and part I of chapter 483 and 19 of chapter 2019-116, Laws of Florida, relating to the abrogation of the scheduled expiration of an amendment to 408.908.

## IX. Additional Information:

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

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 25, 2020:**
The committee substitute:

- Reinstates the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries.
- Extends the current rural hospital designation to 2025 (set to expire June 30, 2021).
- Modifies surveys for nursing home with a Class I or two Class II deficiencies in 60 days, to clarify that the AHCA will continue to conduct licensure surveys every six months until a facility has two consecutive licensure surveys without a citation for a

Class I or Class II deficiency. Reinstates current law and maintains the $6,000 fine for the additional surveys.
- Replaces the term "organization" for home health agencies to align with the AHCA uniform licensing requirements.
- Clarifies the current level 1 background screening requirements for non-emergency transportation providers and brokers remain in place.
- Amends directory language to provide the statutory clarification of retrospective hospital reviews is effective upon becoming a law.
- Removes class III psychiatric facilities from (DRG) payment methodology.
- Removes the nursing home unit cost rate freeze.
- Aligns the state Medicaid anti-kickback law with the federal anti-kickback law.
- Extends the Medicaid statewide dental contracts from five years to six years.
- Requires the Florida Center to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels.
- Expands the list of shoppable health care services that qualify for a shared savings incentive for patients to include services with the most significant price variation. Allows cash and cash equivalent incentives in shared savings incentives.

**CS by Health Policy on January 28, 2020:**
The CS:
- Changes a reference from chapter 624 to chapter 627 to revise and make permanent an exemption from health care clinic licensure for entities owned by an insurance holding company with over $1 billion in annual sales.
- Clarifies that the Legislature's 2001 direction to the AHCA under s. 409.905(5)(a), F.S., to discontinue the Medicaid Program's hospital retrospective review program upon implementing its new authority (also granted in 2001) to prior authorize Medicaid hospital inpatient admissions, may not be construed to prevent MPI from conducting retrospective reviews under s. 409.913, F.S. This provision of the bill takes effect upon becoming law.
- Provides that it is the intent of the Legislature that the bill's amendment to s. 409.905(5)(a), F.S., is intended to confirm and clarify existing law
- Requires the AHCA to establish a six-year, rather than a five-year, contract with each managed care plan selected through the procurement process. Requires the AHCA to extend the term of contracts awarded to managed care plans pursuant to the invitation to negotiate published in July 2017, through December 31, 2024.
- Changes the effective date of the bill to allow for certain sections to take effect upon becoming a law as expressly provided. Unless expressly provided, the bill takes effect on July 1, 2020.

B. Amendments:

None.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-25-20
*Meeting Date*

SB 1726
*Bill Number (if applicable)*

Topic Agency for Health Care

*Amendment Barcode (if applicable)*

Name Dr. Steve Coleman

Job Title Public Policy Director

Address 3116 Capital Cir. NE
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Tallahassee FL 32308
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Email steve_coleman@fabawork.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Association for Behavior Analysis

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

2-25-20 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

*Meeting Date*

1726 [redacted]

*Bill Number (if applicable)*

Topic Long Term Care/AHCA

*Amendment Barcode (if applicable)*

Name Cliff Bauer

Job Title VP - Government Relation

Address 5200 NE 2nd Ave

*Street*

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*City* *State* *Zip*

Phone 954-765-7431

Email cbauer@miamijewishhealth.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against

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

Representing Miami Jewish Health

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

**By** the Committee on Health Policy; and Senator Bean

588-02756-20 20201726c1

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring birth centers to report certain deaths and stillbirths to the agency; removing a requirement that a certain report be submitted annually to the agency; authorizing the agency to prescribe by rule the frequency at which such report is submitted; amending s. 395.003, F.S.; removing a requirement that specified information be listed on licenses for certain facilities; repealing s. 395.7015, F.S., relating to an annual assessment on health care entities; amending s. 395.7016, F.S.; conforming a provision to changes made by the act; amending s. 400.19, F.S.; revising provisions requiring the agency to conduct licensure inspections of nursing homes; requiring the agency to conduct additional licensure surveys under certain circumstances; requiring the agency to assess a specified fine for such surveys; amending s. 400.462, F.S.; revising definitions; amending s. 400.464, F.S.; revising licensure requirements for home health agencies; amending s. 400.471, F.S.; revising provisions related to certain application requirements for home health agencies; amending s. 400.492, F.S.; revising provisions related to services provided by home health agencies during an emergency; amending s. 400.506, F.S.; revising provisions related to licensure requirements for nurse registries; amending s. 400.509, F.S.; revising







588-02756-20 20201726c1

provisions related to the registration of certain service providers; amending s. 400.605, F.S.; removing a requirement that the agency conduct specified inspections of certain licensees; amending s. 400.60501, F.S.; deleting an obsolete date; removing a requirement that the agency develop a specified annual report; amending s. 400.9905, F.S.; revising the definition of the term "clinic"; amending s. 400.991, F.S.; removing the option for health care clinics to file a surety bond under certain circumstances; amending s. 400.9935, F.S.; removing a requirement that certain directors conduct specified reviews; requiring certain clinics to publish and post a schedule of charges; amending s. 408.033, F.S.; conforming a provision to changes made by the act; amending s. 408.061, F.S.; revising provisions requiring health care facilities to submit specified data to the agency; amending s. 408.0611, F.S.; removing the requirement that the agency annually report to the Governor and the Legislature by a specified date on the progress of implementation of electronic prescribing; amending s. 408.062, F.S.; removing requirements that the agency annually report specified information to the Governor and Legislature by a specified date and, instead, requiring the agency to annually publish such information on its website; amending s. 408.063, F.S.; removing a requirement that the agency publish certain annual reports; amending s. 408.803, F.S.; conforming a definition to changes made

by the act; defining the term "low-risk provider"; amending ss. 408.802, 408.820, 408.831, and 408.832, F.S.; conforming provisions to changes made by the act; amending s. 408.806, F.S.; exempting certain providers from a specified inspection; amending s. 408.808, F.S.; authorizing the issuance of a provisional license to certain applicants; amending ss. 408.809 and 409.907, F.S.; revising background screening requirements for certain licensees and providers; amending s. 408.811, F.S.; authorizing the agency to grant certain providers an exemption from a specified inspection under certain circumstances; authorizing the agency to adopt rules to grant waivers of certain inspections and extended inspection periods under certain circumstances; amending s. 408.821, F.S.; revising provisions requiring licensees to have a specified plan; providing requirements for the submission of such plan; amending s. 408.909, F.S.; removing a requirement that the agency and Office of Insurance Regulation evaluate a specified program; amending s. 408.9091, F.S.; requiring the agency and office to each, instead of jointly, submit a specified annual report to the Governor and Legislature; amending s. 409.905, F.S.; providing construction for a provision that requires the agency to discontinue its hospital retrospective review program under certain circumstances; providing legislative intent; amending s. 409.913, F.S.; revising the due date for a certain annual report; deleting the requirement that





certain agencies submit their annual reports jointly; amending s. 409.967, F.S.; revising the length of managed care plan contracts procured by the agency beginning during a specified timeframe; requiring the agency to extend the term of certain existing managed care plan contracts until a specified date; amending s. 429.11, F.S.; removing an authorization for the issuance of a provisional license to certain facilities; amending s. 429.19, F.S.; removing requirements that the agency develop and disseminate a specified list and the Department of Children and Families disseminate such list to certain providers; amending ss. 429.35, 429.905, and 429.929, F.S.; revising provisions requiring a biennial inspection cycle for specified facilities and centers, respectively; repealing part I of ch. 483, F.S., relating to the Florida Multiphasic Health Testing Center Law; redesignating parts II and III of ch. 483, F.S., as parts I and II, respectively; amending ss. 20.43, 381.0034, 456.001, 456.057, 456.076, and 456.47, F.S.; conforming cross-references; providing effective dates.

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

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth

shall be reported immediately to the medical examiner and the agency.

(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency with which it is submitted shall be prescribed by rule of the agency.

Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed on the face of the license. ~~All beds which are not covered by any specialty bed need methodology shall be specified as general beds.~~ A licensed facility shall not operate a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

Section 3. Section 395.7015, Florida Statutes, is repealed.

Section 4. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015, and~~ the reduction by chapter 2000-256, Laws of Florida, in the assessment on hospitals under s. 395.701~~,~~ and to maintain federal approval of the reduced amount of funds deposited into







the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as state match for the state's Medicaid program.

Section 5. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall conduct periodic, ~~every 15 months conduct at least one~~ unannounced licensure inspections ~~inspection~~ to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under ~~the provisions of~~ those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. ~~The survey shall be conducted every 6 months for the next 2 year period~~ If the facility has been cited for a class I deficiency or~~,~~ has been cited for two or more class II deficiencies ~~arising from separate surveys or investigations~~ within a 60-day period, the agency shall conduct an additional licensure survey ~~or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency~~. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the additional licensure survey ~~6-month survey cycle~~. The fine for the additional licensure survey is $3,000 ~~2-year period shall be $6,000, one-half to be paid at the completion of each survey~~. The agency may adjust such ~~this~~ fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify

the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to ~~the provisions of~~ chapter 110.

Section 6. Subsections (12), (14), (17), (21), and (22) of section 400.462, Florida Statutes, are amended to read:

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

(12) "Home health agency" means a person or an entity ~~an organization~~ that provides one or more home health services ~~and staffing services~~.

(14) "Home health services" means health and medical services and medical supplies furnished ~~by an organization~~ to an individual in the individual's home or place of residence. The term includes ~~organizations that provide one or more of~~ the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(17) "Home infusion therapy provider" means a person or an entity ~~an organization~~ that employs, contracts with, or refers a





licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(21) "Nurse registry" means any person or entity that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395, this chapter, or chapter 429 or other business entities.

~~(22) "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.~~

Section 7. Subsections (1), (4), and (5) of section 400.464, Florida Statutes, are amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the

provision of services that require licensure pursuant to this part and part II of chapter 408 and entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in order to operate a home health agency in this state. A license issued on or after July 1, 2018, must specify the home health services the licensee ~~organization~~ is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services that require licensure pursuant to this part without such services being specified on the face of the license issued on or after July 1, 2018, constitutes unlicensed activity as prohibited under s. 408.812.

(4)(a) A licensee ~~An organization~~ that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the licensee ~~organization~~ by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant who fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500. The holder of a license issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license other than the one it has been issued.

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state





attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

(c) A person or entity that ~~who~~ violates paragraph (a) is subject to an injunctive proceeding under s. 408.816. A violation of paragraph (a) or s. 408.812 is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(d) A person or entity that ~~who~~ violates ~~the provisions of~~ paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any person or entity that ~~who~~ commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(e) Any person or entity that ~~who~~ owns, operates, or maintains an unlicensed home health agency and who, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(f) Any home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812.

(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding the provisions of this act.

5. The Department of Children and Families.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to





patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part I of chapter 429, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part IV of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services for which the adult family-care home is licensed under part II of chapter 429, to serve the residents in its facility.

(o) A person or entity that provides skilled care by health care professionals licensed solely under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486.

(p) A person or entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.

Section 8. Paragraph (g) of subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care services must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(g) In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. A home health agency that does not provide skilled care is exempt from this paragraph.





Notwithstanding s. 408.806, the ~~an initial~~ applicant must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for licensure. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes release of, and the agency receives the report of, the accrediting organization.

Section 9. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.—Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being

provided to those patients prior to evacuation. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other health care providers ~~organizations~~ subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving





skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 10. Subsection (4) and paragraph (a) of subsection (5) of section 400.506, Florida Statutes, are amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(4) A licensee who ~~person that~~ provides, offers, or advertises to the public any service for which licensure is required under this section must include in such advertisement the license number issued to the licensee ~~it~~ by the Agency for Health Care Administration. The agency shall assess a fine of not less than $100 against any licensee who fails to include the license number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500.

(5)(a) In addition to the requirements of s. 408.812, any person or entity that ~~who~~ owns, operates, or maintains an unlicensed nurse registry and who, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

Section 11. Subsections (1), (2), (4), and (5) of section 400.509, Florida Statutes, are amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) Any person or entity ~~organization~~ that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any person or entity ~~organization~~ that provides companion services or homemaker services must register with the agency. A person or an entity ~~An organization~~ under contract with the Agency for Persons with Disabilities which provides companion services only for persons with a





developmental disability, as defined in s. 393.063, is exempt from registration.

(2) The requirements of part II of chapter 408 apply to the provision of services that require registration or licensure pursuant to this section and part II of chapter 408 and entities registered by or applying for such registration from the Agency for Health Care Administration pursuant to this section. Each applicant for registration and each registrant must comply with all provisions of part II of chapter 408. Registration or a license issued by the agency is required for a person or an entity to provide ~~the operation of an organization that provides~~ companion services or homemaker services.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person or entity ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee’s or contractor’s job performance. This subsection does not affect

the official immunity of an officer or employee of a public corporation.

(5) A person or an entity that offers or advertises to the public a service for which registration is required must include in its advertisement the registration number issued by the Agency for Health Care Administration.

Section 12. Subsection (3) of section 400.605, Florida Statutes, is amended to read:

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

(3) In accordance with s. 408.811, the agency shall conduct ~~annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The agency shall conduct~~ such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules.

Section 13. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting~~; annual report~~.—

(1) ~~No later than December 31, 2019,~~ The agency shall adopt the national hospice outcome measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state.

(2) The agency shall~~:~~

~~(a)~~ make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to





compare such measures of one or more hospices.

~~(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.~~

Section 14. Subsection (4) of section 400.9905, Florida Statutes, is amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their

respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement





Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees at least





two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner if one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b)

which provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) Orthotic, prosthetic, pediatric cardiology, or perinatology clinical facilities or anesthesia clinical facilities that are not otherwise exempt under paragraph (a) or paragraph (k) and that are a publicly traded corporation or are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that issues securities traded on an





exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

(m) Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and is responsible for the entity's compliance with state law for purposes of this part.

(n) Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459 where the billing for medical services is under a single tax identification number. The application for exemption under this subsection shall contain information that includes: the name, residence, and business address and phone number of the entity that owns the practice; a complete list of the names and contact information of all the officers and directors of the corporation; the name, residence address, business address, and medical license number of each licensed Florida health care practitioner employed by the entity; the corporate tax identification number of the entity seeking an exemption; a listing of health care services to be provided by the entity at the health care clinics owned or operated by the entity and a certified statement prepared by an independent certified public accountant which states that the entity and the health care clinics owned or operated by the entity have not received payment for health care services under personal injury protection insurance coverage for the preceding year. If the

agency determines that an entity which is exempt under this subsection has received payments for medical services under personal injury protection insurance coverage, the agency may deny or revoke the exemption from licensure under this subsection.

(o) Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a mutual insurance holding company, as defined in s. 628.703, with an entity licensed or certified under chapter 627 or chapter 641 which has $1 billion or more in total annual sales in this state.

(p) Entities that are owned by an entity that is a behavioral health service provider in at least 5 states other than Florida and that, together with its affiliates, has $90 million or more in total annual revenues associated with the provision of behavioral health services and where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and who is responsible for the entity's compliance with state law for purposes of this part.

(q) Medicaid providers.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 15. Paragraph (c) of subsection (3) of section 400.991, Florida Statutes, is amended to read:





400.991 License requirements; background screenings; prohibitions.—

(3) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under ss. 408.8065(1) and 408.810(8) ~~s. 408.810(8). As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond~~.

Section 16. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous place in the reception area of any clinic that is an ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must include,

but is not limited to, the 50 services most frequently provided by the clinic. ~~The schedule may group services by three price levels, listing services in each price level.~~ The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is an urgent care center, to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 17. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and health care clinics, ~~and multiphasic testing centers~~ and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 18. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial





reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to, ~~:~~ case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, including patient- ~~with patient~~ and provider-specific identifiers ~~included~~, actual charge data by diagnostic groups or other bundled groupings as specified by rule, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the

standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents including ~~such as~~, but not limited to, ~~:~~ leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. ~~Reported~~ Data elements shall be reported electronically in accordance with the inpatient data reporting instructions as prescribed by agency rule ~~59E-7.012, Florida Administrative Code~~. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 19. Subsection (4) of section 408.0611, Florida Statutes, is amended to read:

408.0611 Electronic prescribing clearinghouse.—

(4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. ~~By January 31 of each year,~~ The agency shall report annually on its website on the progress of implementation of electronic prescribing ~~to the Governor and the Legislature~~. Information reported pursuant to this subsection must ~~shall~~ include federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically transmitted.

Section 20. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:





408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(i) The use of emergency department services by patient acuity level ~~and the implication of increasing hospital cost by providing nonurgent care in emergency departments~~. The agency shall publish annually on its website information ~~submit an annual report~~ based on this monitoring and assessment ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency.

The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall publish annually on its website information ~~submit an annual status report~~ on the collection of data and publication of health care quality measures ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

Section 21. Subsection (5) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.—

~~(5) The agency shall publish annually a comprehensive report of state health expenditures. The report shall identify:~~

~~(a) The contribution of health care dollars made by all payors.~~

~~(b) The dollars expended by type of health care service in Florida.~~

Section 22. Section 408.802, Florida Statutes, is amended to read:

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

(1) Laboratories authorized to perform testing under the





Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102.

(2) Birth centers, as provided under chapter 383.

(3) Abortion clinics, as provided under chapter 390.

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394.

(6) Residential treatment facilities, as provided under part IV of chapter 394.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.

(8) Hospitals, as provided under part I of chapter 395.

(9) Ambulatory surgical centers, as provided under part I of chapter 395.

(10) Nursing homes, as provided under part II of chapter 400.

(11) Assisted living facilities, as provided under part I of chapter 429.

(12) Home health agencies, as provided under part III of chapter 400.

(13) Nurse registries, as provided under part III of chapter 400.

(14) Companion services or homemaker services providers, as provided under part III of chapter 400.

(15) Adult day care centers, as provided under part III of chapter 429.

(16) Hospices, as provided under part IV of chapter 400.

(17) Adult family-care homes, as provided under part II of

chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.

~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 23. Present subsections (10) through (14) of section 408.803, Florida Statutes, are redesignated as subsections (11) through (15), respectively, a new subsection (10) is added to that section, and subsection (3) of that section is amended, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~







and 765.

(10) "Low-risk provider" means nurse registries, home medical equipment providers, and health care clinics.

Section 24. Paragraph (b) of subsection (7) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(7)

(b) An initial inspection is not required for companion services or homemaker services providers~~,~~ as provided under part III of chapter 400, ~~or~~ for health care services pools~~,~~ as provided under part IX of chapter 400, or for low-risk providers as provided under s. 408.811.

Section 25. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(2) PROVISIONAL LICENSE.—An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant for initial licensure or applying for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

Section 26. Subsections (2) and (5) of section 408.809, Florida Statutes, are amended to read:

408.809 Background screening; prohibited offenses.—

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under

chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. ~~Until a specified agency is fully implemented in the clearinghouse created under s. 435.12,~~ The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of ~~the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or~~ the





Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;

(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and

(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

~~(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:~~

~~(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.~~

~~(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.~~

~~(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.~~

Section 27. Subsection (1) of section 408.811, Florida Statutes, is amended to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.—

(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(a) All inspections shall be unannounced, except as specified in s. 408.806.







(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from licensure inspection if the provider or controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory actions, as defined by rule. The agency shall continue to conduct unannounced licensure inspections for at least 10 percent of exempt low-risk providers to verify compliance.

(d) The agency may adopt rules to waive a routine inspection, including inspection for relicensure, or allow for an extended period between relicensure inspections for specific providers based upon:

1. A favorable regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory measures.

2. Outcome measures that demonstrate quality performance.

3. Successful participation in a recognized quality assurance program.

4. Accreditation status.

5. Other measures reflective of quality and safety.

6. The length of time between inspections.

The agency shall continue to conduct unannounced licensure inspections for at least 10 percent of providers that qualify for a waiver or extended period between relicensure inspections.

(e) The agency maintains the authority to conduct an inspection of any provider at any time to determine regulatory

compliance.

Section 28. Subsection (24) of section 408.820, Florida Statutes, is amended to read:

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

~~(24) Multiphasic health testing centers, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 29. Subsections (1) and (2) of section 408.821, Florida Statutes, are amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(1) A licensee required by authorizing statutes and agency rule to have a comprehensive ~~an~~ emergency management ~~operations~~ plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:

(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.

(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.

(c) Respond with necessary plan revisions within 30 days after notification that plan revisions are required.

(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health





department, or Department of Health.

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management ~~operations~~ plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

Section 30. Subsection (3) of section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to those chapters.

Section 31. Section 408.832, Florida Statutes, is amended to read:

408.832 Conflicts.—In case of conflict between the provisions of this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765, the provisions of this part shall prevail.

Section 32. Subsection (9) of section 408.909, Florida

Statutes, is amended to read:

408.909 Health flex plans.—

~~(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 15, 2016, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 33. Paragraph (d) of subsection (10) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(10) PROGRAM EVALUATION.—The agency and the office shall:

~~(d) Jointly submit by March 1, annually, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.~~

Section 34. Effective upon becoming a law, paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be







eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service;

adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However, this subparagraph may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913.

Section 35. It is the intent of the Legislature that section 409.905(5)(a), Florida Statutes, as amended by this act, confirms and clarifies existing law.

Section 36. Subsection (8) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing





services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(8)(a) A level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following:

1. The ~~Each~~ provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity~~, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check~~.

2. Principals of the provider, who include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or

organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

3. Any person who participates or seeks to participate in the Florida Medicaid program by way of rendering services to Medicaid recipients or having direct access to Medicaid recipients, recipient living areas, or the financial, medical, or service records of a Medicaid recipient or who supervises the delivery of goods or services to a Medicaid recipient. This subparagraph does not impose additional screening requirements on any providers licensed under part II of chapter 408.

(b) Notwithstanding paragraph (a) ~~the above~~, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(c) ~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:

1. A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2. Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the





business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(d) ~~(b)~~ Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

Section 37. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 ~~January 1~~, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit reports ~~a joint report~~ to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of

overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(a) "Abuse" means:





1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a

result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing;





to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The

agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.





(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11) The agency shall deny payment or require repayment for





inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13) The agency shall terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2). If the agency determines that the provider did not

participate or acquiesce in the offense, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action.

(14) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor,





investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, or ordered or authorized the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the

goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;





(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time ranging from more than 1 year to 20 years. Termination precludes

participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).





(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that remain in effect for up to 3 years and that are monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action





against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for

Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the





administrative hearing or be excluded from consideration.

(23)(a) In an audit, ~~or~~ investigation, or enforcement action taken for ~~of~~ a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative and~~,~~ legal costs incurred as a result of such audit, investigation, or enforcement action. The costs associated with an investigation, audit, or enforcement action may include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on the case, and any other expenses incurred by the agency or contractor which are associated with the case, including any~~, and~~ expert witness costs and attorney fees incurred on behalf of the agency or contractor if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection

(15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is not subject to further appeal.





(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(26) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the

Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(28) Venue for all Medicaid program integrity cases lies in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within 30 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment





plan or settlement agreement, the agency shall withhold reimbursement payments for Medicaid services until the amount due is paid in full.

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by

the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency's efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of explanations of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation, information on how to report criminal Medicaid fraud to the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of





formatted lists that may be printed or imported into other applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 38. Subsection (1) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year ~~5-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

Section 39. Subsection (6) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 40. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

~~(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list~~







~~shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Care Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.~~

Section 41. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of an ~~the biennial~~ inspection conducted ~~visit required~~ under s. 408.811 or within 30 days after the date of an ~~any~~ interim visit, the agency shall forward the results of the inspection to the local ombudsman council in the district where the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

Section 42. Subsection (2) of section 429.905, Florida Statutes, is amended to read:

429.905 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed

nursing home facilities.—

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection ~~and at least biennially~~ to ensure adequate space and sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule. For the purpose of this subsection, the term "day" means any portion of a 24-hour day.

Section 43. Section 429.929, Florida Statutes, is amended to read:

429.929 Rules establishing standards.—

~~(1)~~ The agency shall adopt rules to implement this part. The rules must include reasonable and fair standards. Any conflict between these standards and those that may be set forth in local, county, or municipal ordinances shall be resolved in favor of those having statewide effect. Such standards must relate to:

(1)~~(a)~~ The maintenance of adult day care centers with respect to plumbing, heating, lighting, ventilation, and other building conditions, including adequate meeting space, to ensure the health, safety, and comfort of participants and protection from fire hazard. Such standards may not conflict with chapter 553 and must be based upon the size of the structure and the







number of participants.

(2)~~(b)~~ The number and qualifications of all personnel employed by adult day care centers who have responsibilities for the care of participants.

(3)~~(c)~~ All sanitary conditions within adult day care centers and their surroundings, including water supply, sewage disposal, food handling, and general hygiene, and maintenance of sanitary conditions, to ensure the health and comfort of participants.

(4)~~(d)~~ Basic services provided by adult day care centers.

(5)~~(e)~~ Supportive and optional services provided by adult day care centers.

(6)~~(f)~~ Data and information relative to participants and programs of adult day care centers, including, but not limited to, the physical and mental capabilities and needs of the participants, the availability, frequency, and intensity of basic services and of supportive and optional services provided, the frequency of participation, the distances traveled by participants, the hours of operation, the number of referrals to other centers or elsewhere, and the incidence of illness.

(7)~~(g)~~ Components of a comprehensive emergency management plan, developed in consultation with the Department of Health and the Division of Emergency Management.

~~(2) Pursuant to this part, s. 408.811, and applicable rules, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period~~

~~immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of provider groups. These standards shall be included in rules adopted by the agency.~~

Section 44. Part I of chapter 483, Florida Statutes, is repealed, and part II and part III of that chapter are redesignated as part I and part II, respectively.

Section 45. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

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

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

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

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter







464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

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

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

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

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

20. Electrolysis, as provided under chapter 478.

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

22. The Board of Clinical Laboratory Personnel, created under part I ~~part II~~ of chapter 483.

23. Medical physicists, as provided under part II ~~part III~~ of chapter 483.

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

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

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

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

28. School psychologists, as provided under chapter 490.

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

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

Section 46. Subsection (3) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or <u>part I</u> ~~part II~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 47. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

456.001 Definitions.—As used in this chapter, the term:

(4) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;





chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; <u>part I or part II</u> ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 48. Paragraphs (h) and (i) of subsection (2) of section 456.057, Florida Statutes, are amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(h) Clinical laboratory personnel licensed under <u>part I</u> ~~part II~~ of chapter 483.

(i) Medical physicists licensed under <u>part II</u> ~~part III~~ of chapter 483.

Section 49. Paragraph (j) of subsection (1) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

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

(j) "Practitioner" means a person licensed, registered, certified, or regulated by the department under part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V,

part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or an applicant for a license, registration, or certification under the same laws.

Section 50. Paragraph (b) of subsection (1) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

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

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multistate health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

Section 51. Except as otherwise expressly provided in this act and except for this section, which shall become effective upon this act becoming a law, this act shall take effect July 1, 2020.

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LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
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| | . | |

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause and insert:

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner and the agency.

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(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency with which it is submitted shall be prescribed by rule of the agency.

Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed on the face of the license. ~~All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds.~~ A licensed facility shall not operate a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

Section 3. Paragraph (g) is added to subsection (18) of section 395.1055, Florida Statutes, to read:

395.1055 Rules and enforcement.—

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(g) The requirement that hospitals licensed for adult diagnostic cardiac catheterization, Level I or Level II adult cardiovascular services participate in the American College of Cardiology – National Cardiovascular Data Registry or the American Heart Association's Get with the Guidelines – Coronary Artery Disease program registry and document an ongoing quality improvement plan to ensure these licensed programs meet or exceed national quality and outcome benchmarks reported by the registry in which they participate. Hospitals licensed for Level



II adult cardiovascular services must also participate in the clinical outcome reporting systems operated by the Society for Thoracic Surgeons.

Section 4. Paragraph (b) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

(b) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or


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6. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2025 ~~2021~~ , if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 5. Section 395.7015, Florida Statutes, is repealed.

Section 6. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015, and~~ the reduction by chapter 2000-256, Laws of Florida, in the assessment on hospitals under s. 395.701~~,~~ and to maintain


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federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as state match for the state's Medicaid program.

Section 7. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall conduct periodic, ~~every 15 months conduct at least one~~ unannounced licensure inspections ~~inspection~~ to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under ~~the provisions of~~ those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. ~~The survey shall be conducted every 6 months for the next 2-year period~~ If the facility has been cited for a class I deficiency or~~,~~ has been cited for two or more class II deficiencies ~~arising from separate surveys or investigations~~ within a 60-day period, the agency shall conduct licensure surveys every 6 months until the facility has two consecutive licensure surveys without a citation for a class I or a class II deficiency ~~or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency~~. In addition to any other fees or fines in this part, the agency shall assess a fine of ~~for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be~~ $6,000 for the additional 6-month licensure surveys~~, one-half to be paid at the completion of each survey~~. The agency may adjust such ~~this~~ fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional


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surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to ~~the provisions of~~ chapter 110.

Section 8. Subsections (12), (14), (17), (21), and (22) of section 400.462, Florida Statutes, are amended to read:

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

(12) "Home health agency" means a person who ~~an organization that~~ provides one or more home health services ~~and staffing services~~.

(14) "Home health services" means health and medical services and medical supplies furnished ~~by an organization~~ to an individual in the individual's home or place of residence. The term includes ~~organizations that provide one or more of~~ the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

(e) Medical supplies, restricted to drugs and biologicals


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prescribed by a physician.

(17) "Home infusion therapy provider" means a person who ~~an organization that~~ employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(21) "Nurse registry" means any person who ~~that~~ procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395, this chapter, or chapter 429 or other business entities.

~~(22) "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.~~

Section 9. Subsection (1), paragraph (a) of subsection (4), and subsection (5) of section 400.464, Florida Statutes, are


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amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in order to operate a home health agency in this state. A license issued on or after July 1, 2018, must specify the home health services the licensee ~~organization~~ is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services that require licensure pursuant to this part without such services being specified on the face of the license issued on or after July 1, 2018, constitutes unlicensed activity as prohibited under s. 408.812.

(4)(a) A licensee ~~An organization~~ that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the licensee ~~organization~~ by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant who fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500. The holder of a license issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license other than the one it has been issued.


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(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding the provisions of this act.

5. The Department of Children and Families.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to


patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part I of chapter 429, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part IV of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.


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(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services for which the adult family-care home is licensed under part II of chapter 429, to serve the residents in its facility.

(o) A person who provides skilled care by health care professionals licensed solely under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486. This exemption does not authorize an individual to perform home health services without the required professional license.

(p) A person or entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.

Section 10. Paragraph (g) of subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care services must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(g) In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and

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part II of chapter 408. A home health agency that does not provide skilled care is exempt from this paragraph. Notwithstanding s. 408.806, the ~~an initial~~ applicant must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for licensure. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes release of, and the agency receives the report of, the accrediting organization.

Section 11. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.—Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff


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to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other health care providers ~~organizations~~ subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each


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patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 12. Subsection (4) and paragraph (a) of subsection (5) of section 400.506, Florida Statutes, are amended to read:


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400.506 Licensure of nurse registries; requirements; penalties.—

(4) A licensee who ~~person that~~ provides, offers, or advertises to the public any service for which licensure is required under this section must include in such advertisement the license number issued to the licensee ~~it~~ by the Agency for Health Care Administration. The agency shall assess a fine of not less than $100 against any licensee who fails to include the license number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500.

(5)(a) In addition to the requirements of s. 408.812, any person or entity that ~~who~~ owns, operates, or maintains an unlicensed nurse registry and who, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

Section 13. Subsections (1), (2), (4), and (5) of section 400.509, Florida Statutes, are amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) Any person who ~~organization that~~ provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any person who ~~organization that~~ provides companion services or homemaker services must register with the agency. A person ~~An organization~~ under contract with the Agency


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for Persons with Disabilities who ~~which~~ provides companion services only for persons with a developmental disability, as defined in s. 393.063, is exempt from registration.

(2) The requirements of part II of chapter 408 apply to the provision of services that require registration or licensure pursuant to this section and part II of chapter 408 and entities registered by or applying for such registration from the Agency for Health Care Administration pursuant to this section. Each applicant for registration and each registrant must comply with all provisions of part II of chapter 408. Registration or a license issued by the agency is required for a person to provide ~~the operation of an organization that provides~~ companion services or homemaker services.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's or


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contractor's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(5) A person who ~~that~~ offers or advertises to the public a service for which registration is required must include in its advertisement the registration number issued by the Agency for Health Care Administration.

Section 14. Subsection (3) of section 400.605, Florida Statutes, is amended to read:

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

(3) In accordance with s. 408.811, the agency shall conduct ~~annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The agency shall conduct~~ such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules.

Section 15. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting~~; annual report~~.—

(1) ~~No later than December 31, 2019,~~ The agency shall adopt the national hospice outcome measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state.

(2) The agency shall~~:~~

~~(a)~~ make available to the public the national hospice outcome measures and survey data in a format that is


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comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices.

~~(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.~~

Section 16. Subsection (4) of section 400.9905, Florida Statutes, is amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care


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services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid


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services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital


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under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan


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under 26 U.S.C. s. 409 that has a board of trustees at least two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner if one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity’s compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner’s license, except that, for the purposes of


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this part, a clinic owned by a licensee in s. 456.053(3)(b) which provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) Orthotic, prosthetic, pediatric cardiology, or perinatology clinical facilities or anesthesia clinical facilities that are not otherwise exempt under paragraph (a) or paragraph (k) and that are a publicly traded corporation or are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded


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corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

(m) Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and is responsible for the entity's compliance with state law for purposes of this part.

(n) Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459 where the billing for medical services is under a single tax identification number. The application for exemption under this subsection shall contain information that includes: the name, residence, and business address and phone number of the entity that owns the practice; a complete list of the names and contact information of all the officers and directors of the corporation; the name, residence address, business address, and medical license number of each licensed Florida health care practitioner employed by the entity; the corporate tax identification number of the entity seeking an exemption; a listing of health care services to be provided by the entity at the health care clinics owned or operated by the entity and a certified statement prepared by an independent certified public accountant which states that the entity and the health care clinics owned or operated by the entity have not received payment for health care services under personal injury

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protection insurance coverage for the preceding year. If the agency determines that an entity which is exempt under this subsection has received payments for medical services under personal injury protection insurance coverage, the agency may deny or revoke the exemption from licensure under this subsection.

(o) Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a mutual insurance holding company, as defined in s. 628.703, with an entity licensed or certified under chapter 627 or chapter 641 which has $1 billion or more in total annual sales in this state.

(p) Entities that are owned by an entity that is a behavioral health service provider in at least 5 states other than Florida and that, together with its affiliates, has $90 million or more in total annual revenues associated with the provision of behavioral health services and where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and for the entity's compliance with state law for purposes of this part.

(q) Medicaid providers.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 17. Paragraph (c) of subsection (3) of section

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400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.—

(3) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under ss. 408.8065(1) and 408.810(8) ~~s. 408.810(8). As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond~~.

Section 18. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous place in the reception area of any clinic that is an ~~the~~ urgent


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care center as defined in s. 395.002(29)(b) and must include, but is not limited to, the 50 services most frequently provided by the clinic. ~~The schedule may group services by three price levels, listing services in each price level.~~ The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is an urgent care center, to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 19. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and health care clinics, ~~and multiphasic testing centers~~ and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 20. Effective January 1, 2021, paragraph (l) is added to subsection (3) of section 408.05, Florida Statutes, to


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read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(l) By July 1 of each year, publish a report identifying the health care services with the most significant price variation both statewide and regionally.

Section 21. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to, ~~:~~ case-mix data, patient admission and discharge data, hospital emergency department data which shall include the


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number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, including patient- ~~with patient~~ and provider-specific identifiers ~~included~~, actual charge data by diagnostic groups or other bundled groupings as specified by rule, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents including ~~such as~~, but not limited to, ~~:~~ leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. ~~Reported~~ Data elements shall be reported electronically in accordance with the inpatient data reporting instructions as prescribed by agency rule ~~59E-7.012, Florida Administrative Code~~. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 22. Subsection (4) of section 408.0611, Florida Statutes, is amended to read:

408.0611 Electronic prescribing clearinghouse.—

(4) Pursuant to s. 408.061, the agency shall monitor the


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implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. ~~By January 31 of each year,~~ The agency shall report annually on its website on the progress of implementation of electronic prescribing ~~to the Governor and the Legislature~~. Information reported pursuant to this subsection must ~~shall~~ include federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically transmitted.

Section 23. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(i) The use of emergency department services by patient acuity level ~~and the implication of increasing hospital cost by providing nonurgent care in emergency departments~~. The agency shall annually publish on its website information ~~submit an annual report~~ based on this monitoring and assessment ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes,

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length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall annually publish on its website information ~~submit an annual status report~~ on the collection of data and publication of health care quality measures ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

Section 24. Subsection (5) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.—

~~(5) The agency shall publish annually a comprehensive~~


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~~report of state health expenditures. The report shall identify:~~

~~(a) The contribution of health care dollars made by all payors.~~

~~(b) The dollars expended by type of health care service in Florida.~~

Section 25. Section 408.802, Florida Statutes, is amended to read:

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

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102.

(2) Birth centers, as provided under chapter 383.

(3) Abortion clinics, as provided under chapter 390.

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394.

(6) Residential treatment facilities, as provided under part IV of chapter 394.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.

(8) Hospitals, as provided under part I of chapter 395.

(9) Ambulatory surgical centers, as provided under part I of chapter 395.

(10) Nursing homes, as provided under part II of chapter


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400.

(11) Assisted living facilities, as provided under part I of chapter 429.

(12) Home health agencies, as provided under part III of chapter 400.

(13) Nurse registries, as provided under part III of chapter 400.

(14) Companion services or homemaker services providers, as provided under part III of chapter 400.

(15) Adult day care centers, as provided under part III of chapter 429.

(16) Hospices, as provided under part IV of chapter 400.

(17) Adult family-care homes, as provided under part II of chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.


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~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 26. Present subsections (10) through (14) of section 408.803, Florida Statutes, are redesignated as subsections (11) through (15), respectively, a new subsection (10) is added to that section, and subsection (3) of that section is amended, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765.

(10) "Low-risk provider" means nurse registries, home medical equipment providers, and health care clinics.

Section 27. Paragraph (b) of subsection (7) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(7)

(b) An initial inspection is not required for companion services or homemaker services providers~~,~~ as provided under part III of chapter 400, ~~or~~ for health care services pools~~,~~ as provided under part IX of chapter 400, or for low-risk providers as provided under s. 408.811.

Section 28. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(2) PROVISIONAL LICENSE.—An applicant against whom a


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proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant for initial licensure or an applicant applying for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

Section 29. Subsections (2) and (5) of section 408.809, Florida Statutes, are amended to read:

408.809 Background screening; prohibited offenses.—

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person’s fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person’s fingerprints are enrolled in the Federal Bureau of Investigation’s national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s.

943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. ~~Until a specified agency is fully implemented in the clearinghouse created under s. 435.12,~~ The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of ~~the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or~~ the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;

(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and

(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

~~(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified~~


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~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:~~

~~(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.~~

~~(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.~~

~~(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.~~

Section 30. Subsection (1) of section 408.811, Florida Statutes, is amended to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.—

(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance


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with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(a) All inspections shall be unannounced, except as specified in s. 408.806.

(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from licensure inspection if the provider or controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory actions, as defined by rule. The agency shall continue to conduct unannounced licensure inspections for at least 10 percent of exempt low-risk providers to verify compliance.

(d) The agency may adopt rules to waive a routine inspection, including inspection for relicensure, or allow for an extended period between relicensure inspections for specific providers based upon all of the following:

1. A favorable regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory

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measures.

2. Outcome measures that demonstrate quality performance.

3. Successful participation in a recognized quality assurance program.

4. Accreditation status.

5. Other measures reflective of quality and safety.

6. The length of time between inspections.

The agency shall continue to conduct unannounced licensure inspections for at least 10 percent of providers that qualify for a waiver or extended period between relicensure inspections.

(e) The agency maintains the authority to conduct an inspection of any provider at any time to determine regulatory compliance.

Section 31. Subsection (24) of section 408.820, Florida Statutes, is amended to read:

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

~~(24) Multiphasic health testing centers, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 32. Subsections (1) and (2) of section 408.821, Florida Statutes, are amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(1) A licensee required by authorizing statutes and agency rule to have a comprehensive ~~an~~ emergency management ~~operations~~ plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its

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comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:

(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.

(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.

(c) Respond with necessary plan revisions within 30 days after notification that plan revisions are required.

(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management ~~operations~~ plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

Section 33. Subsection (3) of section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency


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for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to those chapters.

Section 34. Section 408.832, Florida Statutes, is amended to read:

408.832 Conflicts.—In case of conflict between the provisions of this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765, the provisions of this part shall prevail.

Section 35. Subsection (9) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

~~(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 15, 2016, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 36. Paragraph (d) of subsection (10) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—


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(10) PROGRAM EVALUATION.—The agency and the office shall:

~~(d) Jointly submit by March 1, annually, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.~~

Section 37. Effective upon becoming a law, paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for


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inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. Upon implementing the prior authorization program for


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hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However, this subparagraph may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913, including, but not limited to, reviews in which an overpayment is suspected due to a mistake or submission of an improper claim or for other reasons that do not rise to the level of fraud or abuse.

Section 38. It is the intent of the Legislature that section 409.905(5)(a), Florida Statutes, as amended by this act, confirms and clarifies existing law. This section shall take effect upon becoming a law.

Section 39. Subsection (8) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(8)(a) A level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following:

1. The ~~Each~~ provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity~~, seeking to participate in the Medicaid program~~


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~~must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check~~.

2. Principals of the provider, who include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

3. Any person who participates or seeks to participate in the Florida Medicaid program by way of rendering services to Medicaid recipients or having direct access to Medicaid


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recipients, recipient living areas, or the financial, medical, or service records of a Medicaid recipient or who supervises the delivery of goods or services to a Medicaid recipient. This subparagraph does not impose additional screening requirements on any providers licensed under part II of chapter 408 or transportation service providers contracted with a transportation broker subject to this paragraph while administering the Medicaid transportation benefit.

(b) Notwithstanding paragraph (a) ~~the above~~, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(c)~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:

1. A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2. Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(d)~~(b)~~ Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

Section 40. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:


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

(1) Reimbursement to hospitals licensed under part I of


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chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided in s. 409.905(5), except as otherwise provided in this subsection.

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

~~e. Class III psychiatric hospitals.~~

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in


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any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.

Section 41. Effective June 30, 2020, section 19 of chapter 2019-116, Laws of Florida, is repealed.

Section 42. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent


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possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 ~~January 1~~, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit reports ~~a joint report~~ to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to


prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.


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(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by


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contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the


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agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency


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informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical


basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods


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furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11) The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;


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(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13) The agency shall terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2). If the agency determines that the provider did not participate or acquiesce in the offense, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action.

(14) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in


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any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with


provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, or ordered or authorized the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient’s responsible party improperly for amounts that should not have been so collected or billed by reason of the provider’s billing the Medicaid program for the same service;


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(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer,


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director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time ranging from more than 1 year to 20 years. Termination precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional


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services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that remain in effect for up to 3 years and that are monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.


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If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care


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provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited


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to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written


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documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

(23)(a) In an audit, ~~or~~ investigation, or enforcement action taken for ~~of~~ a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative and~~,~~ legal costs incurred as a result of such audit, investigation, or enforcement action. The costs associated with an investigation, audit, or enforcement action may include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on the case, and any other expenses incurred by the agency or contractor which are associated with the case, including any~~, and~~ expert witness costs and attorney fees incurred on behalf of the agency or contractor if the agency's findings were not contested by the provider or, if

contested, the agency ultimately prevailed.

(b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider’s or person’s name and license number and the specific reasons for sanction.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful


misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is not subject to further appeal.

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(26) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy


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provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(28) Venue for all Medicaid program integrity cases lies in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider’s Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider’s practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider’s total practice.


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(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within 30 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold reimbursement payments for Medicaid services until the amount due is paid in full.

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that



provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient’s medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency’s efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of explanations of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including information on how to report inappropriate or incorrect billing to the agency or other law enforcement


entities for review or investigation, information on how to report criminal Medicaid fraud to the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency,


the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 43. Paragraph (a) of subsection (2) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(2)(a) A person may not:

1. Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.

2. Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

3. Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient


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under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.

4. Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider.

5. Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program. This subparagraph does not apply to any discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or regulations adopted thereunder.

6. Knowingly submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider.

7. Knowingly use or endeavor to use a Medicaid provider’s identification number or a Medicaid recipient’s identification number to make, cause to be made, or aid and abet in the making


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of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

Section 44. Subsection (1) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year ~~5-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

Section 45. Paragraph (b) of subsection (5) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the

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entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process. Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 ~~5~~ years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.

Section 46. Subsection (6) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 47. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines;


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grounds.—

~~(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Care Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.~~

Section 48. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of an ~~the biennial~~ inspection conducted ~~visit required~~ under s. 408.811 or within 30 days after the date of an ~~any~~ interim visit, the agency shall forward the results of the inspection to the local ombudsman council in the district where the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the


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district Adult Services and Mental Health Program Offices.

Section 49. Subsection (2) of section 429.905, Florida Statutes, is amended to read:

429.905 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.—

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection ~~and at least biennially~~ to ensure adequate space and sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule. For the purpose of this subsection, the term "day" means any portion of a 24-hour day.

Section 50. Section 429.929, Florida Statutes, is amended to read:

429.929 Rules establishing standards.—

~~(1)~~ The agency shall adopt rules to implement this part. The rules must include reasonable and fair standards. Any conflict between these standards and those that may be set forth in local, county, or municipal ordinances shall be resolved in favor of those having statewide effect. Such standards must relate to:

(1)~~(a)~~ The maintenance of adult day care centers with


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respect to plumbing, heating, lighting, ventilation, and other building conditions, including adequate meeting space, to ensure the health, safety, and comfort of participants and protection from fire hazard. Such standards may not conflict with chapter 553 and must be based upon the size of the structure and the number of participants.

(2) ~~(b)~~ The number and qualifications of all personnel employed by adult day care centers who have responsibilities for the care of participants.

(3) ~~(c)~~ All sanitary conditions within adult day care centers and their surroundings, including water supply, sewage disposal, food handling, and general hygiene, and maintenance of sanitary conditions, to ensure the health and comfort of participants.

(4) ~~(d)~~ Basic services provided by adult day care centers.

(5) ~~(e)~~ Supportive and optional services provided by adult day care centers.

(6) ~~(f)~~ Data and information relative to participants and programs of adult day care centers, including, but not limited to, the physical and mental capabilities and needs of the participants, the availability, frequency, and intensity of basic services and of supportive and optional services provided, the frequency of participation, the distances traveled by participants, the hours of operation, the number of referrals to other centers or elsewhere, and the incidence of illness.

(7) ~~(g)~~ Components of a comprehensive emergency management plan, developed in consultation with the Department of Health and the Division of Emergency Management.

~~(2) Pursuant to this part, s. 408.811, and applicable~~


~~rules, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of provider groups. These standards shall be included in rules adopted by the agency.~~

Section 51. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.


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7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 52. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and


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include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 53. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section


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641.31076, Florida Statutes, are amended to read:

641.31076 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization that offers a shared savings incentive program must:


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(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the subscriber's flexible spending account, health savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent ~~such that the amount does not constitute income to the subscriber~~.

Section 54. Part I of chapter 483, Florida Statutes, is repealed, and part II and part III of that chapter are redesignated as part I and part II, respectively.

Section 55. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

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

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

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

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.


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8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

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

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

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

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

20. Electrolysis, as provided under chapter 478.

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

22. The Board of Clinical Laboratory Personnel, created under part I ~~part II~~ of chapter 483.

23. Medical physicists, as provided under part II ~~part III~~ of chapter 483.

24. The Board of Opticianry, created under part I of


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chapter 484.

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

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

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

28. School psychologists, as provided under chapter 490.

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

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

Section 56. Subsection (3) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or part I ~~part II~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 57. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

456.001 Definitions.—As used in this chapter, the term:

(4) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460;


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chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 58. Paragraphs (h) and (i) of subsection (2) of section 456.057, Florida Statutes, are amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(h) Clinical laboratory personnel licensed under part I ~~part II~~ of chapter 483.

(i) Medical physicists licensed under part II ~~part III~~ of chapter 483.

Section 59. Paragraph (j) of subsection (1) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

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

(j) "Practitioner" means a person licensed, registered, certified, or regulated by the department under part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;

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chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or an applicant for a license, registration, or certification under the same laws.

Section 60. Paragraph (b) of subsection (1) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

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

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multistate health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

Section 61. Except as otherwise expressly provided in this act and except for this section, which shall become effective upon this act becoming a law, this act shall take effect July 1, 2020.

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

And the title is amended as follows:

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Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring birth centers to report certain deaths and stillbirths to the agency; revising the frequency with which a certain report must be submitted to the agency; authorizing the agency to prescribe by rule the frequency with which such report is submitted; amending s. 395.003, F.S.; removing a requirement that specified information be listed on licenses for certain facilities; amending s. 395.1055, F.S.; requiring the agency to adopt specified rules related to ongoing quality improvement programs for certain cardiac programs; amending s. 395.602, F.S.; revising the definition of the term "rural hospital"; repealing s. 395.7015, F.S., relating to an annual assessment on health care entities; amending s. 395.7016, F.S.; conforming a provision to changes made by the act; amending s. 400.19, F.S.; revising provisions requiring the agency to conduct licensure inspections of nursing homes; requiring the agency to conduct additional licensure surveys under certain circumstances; requiring the agency to assess a specified fine for such surveys; amending s. 400.462, F.S.; revising definitions; amending s. 400.464, F.S.; revising exemptions from licensure requirements for home health agencies; amending s. 400.471, F.S.;

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revising provisions related to certain application requirements for home health agencies; amending s. 400.492, F.S.; revising provisions related to services provided by home health agencies during an emergency; amending s. 400.506, F.S.; revising provisions related to licensure requirements for nurse registries; amending s. 400.509, F.S.; revising provisions related to the registration of certain service providers; amending s. 400.605, F.S.; removing a requirement that the agency conduct specified inspections of certain licensees; amending s. 400.60501, F.S.; deleting an obsolete date; removing a requirement that the agency develop a specified annual report; amending s. 400.9905, F.S.; revising the definition of the term "clinic"; amending s. 400.991, F.S.; removing the option for health care clinics to file a surety bond under certain circumstances; amending s. 400.9935, F.S.; revising provisions related to the schedule of charges published and posted by certain clinics; specifying that urgent care centers are subject to such requirements; amending s. 408.033, F.S.; conforming a provision to changes made by the act; amending s. 408.05, F.S.; requiring the agency to publish by a specified date an annual report identifying certain health care services; amending s. 408.061, F.S.; revising provisions requiring health care facilities to submit specified data to the agency; amending s. 408.0611, F.S.; removing a requirement that the agency annually report to the


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Governor and the Legislature by a specified date on the progress of implementation of electronic prescribing, and instead, requiring the agency to annually publish such information on its website; amending s. 408.062, F.S.; removing requirements that the agency annually report specified information to the Governor and Legislature by a specified date and, instead, requiring the agency to annually publish such information on its website; amending s. 408.063, F.S.; removing a requirement that the agency publish certain annual reports; amending s. 408.803, F.S.; conforming a definition to changes made by the act; defining the term "low-risk provider"; amending ss. 408.802, 408.820, 408.831, and 408.832, F.S.; conforming provisions to changes made by the act; amending s. 408.806, F.S.; exempting certain providers from a specified inspection; amending s. 408.808, F.S.; authorizing the issuance of a provisional license to certain applicants; amending ss. 408.809 and 409.907, F.S.; revising background screening requirements for certain licensees and providers; amending s. 408.811, F.S.; authorizing the agency to grant certain providers an exemption from a specified inspection under certain circumstances; authorizing the agency to adopt rules to grant waivers of certain inspections and allow for extended inspection periods under certain circumstances; requiring the agency to conduct unannounced licensure inspections of certain providers during a specified time period; providing that the


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agency may conduct regulatory compliance inspections of providers at any time; amending s. 408.821, F.S.; revising provisions requiring licensees to have a specified plan; providing requirements for the submission of such plan; amending s. 408.909, F.S.; removing a requirement that the agency and Office of Insurance Regulation evaluate a specified program; amending s. 408.9091, F.S.; deleting a requirement that the agency and office submit a specified joint annual report to the Governor and Legislature; amending s. 409.905, F.S.; providing construction for a provision that requires the agency to discontinue its hospital retrospective review program under certain circumstances; providing legislative intent; amending 409.908, F.S.; revising provisions related to the prospective payment methodology for certain Medicaid provider reimbursements; repealing s. 19 of chapter 2019-116, Laws of Florida, relating to the abrogation of the scheduled expiration of an amendment to s. 408.908(23), F.S., and the scheduled reversion of the text of that subsection; amending s. 409.913, F.S.; revising the due date for a certain annual report; deleting the requirement that certain agencies submit their annual reports jointly; providing that the agency or its contractor is entitled to recover certain costs and attorney fees related to audits, investigations, or enforcement actions conducted by the agency or its contractor; amending s. 409.920, F.S.; revising provisions related to prohibited


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referral practices in the Medicaid program; amending ss. 409.967 and 409.973, F.S.; revising the length of managed care plan contracts procured by the agency beginning during a specified timeframe; requiring the agency to extend the term of certain existing managed care plan contracts until a specified date; amending s. 429.11, F.S.; removing an authorization for the issuance of a provisional license to certain facilities; amending s. 429.19, F.S.; removing requirements that the agency develop and disseminate a specified list and the Department of Children and Families disseminate such list to certain providers; amending ss. 429.35 and 429.905, F.S.; revising provisions requiring a biennial inspection cycle for specified facilities; amending s. 429.929, F.S.; revising provisions requiring a biennial inspection cycle for adult day care centers; amending ss. 627.6387, 627.6648, and 641.31076, F.S.; revising the definition of the term "shoppable health care service"; revising duties of certain health insurers and health maintenance organizations; repealing part I of ch. 483, F.S., relating to the Florida Multiphasic Health Testing Center Law; redesignating parts II and III of ch. 483, F.S., as parts I and II, respectively; amending ss. 20.43, 381.0034, 456.001, 456.057, 456.076, and 456.47, F.S.; conforming cross-references; providing effective dates.

860528

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

**Senate Amendment to Amendment (441796)**

Delete line 113

and insert:

deficiencies arising from separate surveys or investigations

127166

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

**Senate Amendment to Amendment (441796) (with directory and title amendments)**

Between lines 1393 and 1394
insert:

(23)(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for county health departments effective July 1, 2011. Reimbursement rates shall be as provided in the General Appropriations Act.

127166

(b)1. Base rate reimbursement for inpatient services under a diagnosis-related group payment methodology shall be provided in the General Appropriations Act.

2. Base rate reimbursement for outpatient services under an enhanced ambulatory payment group methodology shall be provided in the General Appropriations Act.

3. Prospective payment system reimbursement for nursing home services shall be as provided in subsection (2) and in the General Appropriations Act.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:

Delete line 1315
and insert:
409.908, Florida Statutes, is amended, and subsection (23) of that section is reenacted, to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:

Delete lines 2666 - 2669
and insert:
Medicaid provider reimbursements; reenacting s. 409.908(23), relating to reimbursement of Medicaid providers for certain services; repealing s. 19 of chapter 2019-116, Laws of Florida, relating to the abrogation of the scheduled expiration of an amendment to s. 409.908(23), F.S., and the scheduled reversion

283312

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: WD | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Rader) recommended the following:

**Senate Amendment to Amendment (441796) (with title amendment)**

Delete lines 2314 - 2417
and insert:
subsection (2) and paragraphs (d) and (e) of subsection (3) of section 627.6387, Florida Statutes, are amended to read:
627.6387 Shared savings incentive program.—
(2) As used in this section, the term:
(e) "Shoppable health care service" means a lower-cost,

283312

high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(d) Publish on a webpage easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 50 ~~25~~ percent of the savings

283312

generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 52. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraphs (d) and (e) of subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests

283312

and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(d) Publish on a webpage easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 50 ~~25~~ percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the insured's flexible spending account, health

283312

savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 53. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraphs (d) and (e) of subsection (3) of section 641.31076, Florida Statutes, are amended to read:

641.31076 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber

283312

when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization that offers a shared savings incentive program must:

(d) Publish on a webpage easily accessible to subscribers and to applicants for coverage a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 50 ~~25~~ percent of the savings generated by the subscriber's participation in any shared savings incentive offered by the health maintenance organization. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health maintenance organization and approved by the office.

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

And the title is amended as follows:

Delete line 2698

and insert:

service"; revising the minimum amount of certain incentives health insurers and health maintenance organizations may offer insureds or subscribers; revising duties of certain health insurers

588700

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: WD | . | |
| 02/25/2020 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Rader) recommended the following:

**Senate Amendment to Amendment (441796) (with title amendment)**

Delete lines 2315 - 2424
and insert:
627.6387, Florida Statutes, are amended, and paragraph (g) is added to subsection (3) of that section, to read:
627.6387 Shared savings incentive program.—
(2) As used in this section, the term:
(e) "Shoppable health care service" means a lower-cost,


588700

high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the

588700

insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

(g) If a health insurer offers cash or a cash equivalent, provide the insured with a document approved by the commission which explains the shared savings incentive in plain language and which must include the following statement in 12-point bold type:

I UNDERSTAND THAT IF I RECEIVE CASH OR A CASH EQUIVALENT, IT COUNTS AS INCOME TO ME AND MAY CAUSE ME TO OWE MORE INCOME TAX. I ALSO UNDERSTAND THAT IF I RECEIVE INCOME-BASED BENEFITS, THESE BENEFITS MAY BE AFFECTED IF I RECEIVE CASH OR A CASH EQUIVALENT FROM THE SHARED SAVINGS PROGRAM.

Section 52. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6648, Florida Statutes, are amended, and paragraph (g) is added to subsection (3) of that section, to read:

627.6648 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

588700

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

(g) If a health insurer offers cash or a cash equivalent, provide the insured with a document approved by the commission which explains the shared savings incentive in plain language and which must include the following statement in 12-point bold type:

I UNDERSTAND THAT IF I RECEIVE CASH OR A CASH EQUIVALENT,

588700

IT COUNTS AS INCOME TO ME AND MAY CAUSE ME TO OWE MORE INCOME TAX. I ALSO UNDERSTAND THAT IF I RECEIVE INCOME-BASED BENEFITS, THESE BENEFITS MAY BE AFFECTED IF I RECEIVE CASH OR A CASH EQUIVALENT FROM THE SHARED SAVINGS PROGRAM.

Section 53. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 641.31076, Florida Statutes, are amended, and paragraph (g) is added to subsection (3) of that section, to read:

641.31076 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

588700

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, ~~or~~ credit the shared savings incentive amount to the subscriber's flexible spending account, health savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent ~~such that the amount does not constitute income to the subscriber~~.

(g) If a health maintenance organization offers cash or a cash equivalent, provide the subscriber with a document approved by the commission which explains the shared savings incentive in plain language and which must include the following statement in 12-point bold type:

I UNDERSTAND THAT IF I RECEIVE CASH OR A CASH EQUIVALENT, IT COUNTS AS INCOME TO ME AND MAY CAUSE ME TO OWE MORE INCOME TAX. I ALSO UNDERSTAND THAT IF I RECEIVE INCOME-BASED BENEFITS, THESE BENEFITS MAY BE AFFECTED IF I RECEIVE CASH OR A CASH EQUIVALENT FROM THE SHARED SAVINGS PROGRAM.

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

And the title is amended as follows:


588700

Delete line 2699

and insert:

and health maintenance organizations; requiring certain health insurers and health maintenance organizations to provide to insureds and subscribers a specified document under certain circumstances; providing requirements for the content of the document; repealing part I

# CourtSmart Tag Report

**Room:** KN 412 **Case No.:** **Type:**
**Caption:** Senate Appropriations Subcommittee on Health and Human Services **Judge:**

**Started: 2/25/2020 1:04:48 PM**
**Ends: 2/25/2020 3:00:02 PM** **Length: 01:55:15**

**1:04:49 PM** Sen. Bean (Chair)
**1:07:09 PM** S 1338, Prescription Drug Coverage
**1:07:24 PM** Sen. Wright
**1:08:43 PM** Am. 636790
**1:09:44 PM** Am. 636790 (adopted)
**1:09:46 PM** S 1338 (cont.)
**1:09:51 PM** Appearances: Chris Nuland, Lobbyist, Florida Gastroenterologic Society (waives in support of the bill)
**1:10:10 PM** Sen. Harrell
**1:10:20 PM** Barney Bishop III, CEO, Florida Smart Justice Alliance (waives in support of the bill)
**1:10:31 PM** Shane Abbott, Pharmacist, The Prescription Place (speaks in support of the bill)
**1:11:56 PM** Jeff Kottkamp, Small Business Pharmacies Aligned for Reform (speaks in support of the bill)
**1:14:21 PM** Alex Herwig, Pharmacist, Small Business Pharmacies Aligned for Reform (waives in support of the bill)
**1:14:36 PM** Kevin Duane, Pharmacist, Small Business Pharmacies Aligned for Reform (speaks in support of the bill)
**1:16:55 PM** John O'Brien, Florida Pharmacy Association (speaks in support of the bill)
**1:20:50 PM** Michael Fischer, Florida Independent Pharmacy Network (waives in support of the bill)
**1:21:12 PM** Scott Woods, Assistant Vice-President, State Affairs, Pharmaceutical Care Management Association (speaks in support of the bill)
**1:23:21 PM** Michael Jackson, Executive Vice-President and CEO, Florida Pharmacy Association (waives in support of the bill)
**1:23:34 PM** David Poole, Director of Legislative Affairs, AIDS Healthcare Foundation (waives in support of the bill)
**1:23:54 PM** Sen. Rader
**1:25:10 PM** Sen. Wright
**1:25:30 PM** Sen. Farmer
**1:26:52 PM** Sen. Harrell
**1:28:14 PM** Sen. Wright
**1:29:07 PM** S 1338 (reported favorably)
**1:29:11 PM** S 1544, Long-term Care
**1:29:34 PM** Sen. Albritton
**1:30:08 PM** Appearances: Dorene Barker, Associate State Director, AARP Florida (waives in support of the bill)
**1:30:19 PM** Robert Beck, PinPoint Results, Florida's Area Agencies on Aging (waives in support of the bill)
**1:30:30 PM** Tanya Jackson, Lobbyist, 1199 SEIU Healthcare Workers (waives in support of the bill)
**1:30:52 PM** Sen. Rader
**1:31:25 PM** Sen. Albritton
**1:31:32 PM** Sen. Rader
**1:31:38 PM** Sen. Albritton
**1:32:03 PM** S 1544 (reported favorably)
**1:32:18 PM** S 1296, Health Access Dental Licenses
**1:32:37 PM** Sen. Berman
**1:33:26 PM** Appearances: Eric Stern, Legislative Committee Member, Florida PTA (waives in support of the bill)
**1:33:36 PM** Joe Anne Hart, Chief Legislative Officer, Florida Dental Association (waives in support of the bill)
**1:34:22 PM** S 1296 (reported favorably)
**1:34:40 PM** S 714, Testing for and Treatment of Influenza
**1:36:57 PM** Sen. Bean
**1:37:02 PM** Sen. Hutson
**1:37:27 PM** Sen. Bean
**1:37:37 PM** Sen. Hutson
**1:38:32 PM** Sen. Rouson
**1:38:56 PM** Sen. Hutson
**1:39:16 PM** Sen. Rouson
**1:39:37 PM** Sen. Hutson
**1:40:29 PM** Sen. Rouson
**1:41:14 PM** Sen. Hutson

**1:42:03 PM** Sen. Harrell
**1:42:12 PM** Sen. Hutson
**1:42:25 PM** Sen. Harrell
**1:42:52 PM** Sen. Hutson
**1:43:25 PM** Sen. Harrell
**1:43:41 PM** Sen. Hutson
**1:44:08 PM** Sen. Book
**1:44:29 PM** Sen. Hutson
**1:45:04 PM** Sen. Book
**1:45:20 PM** Sen. Hutson
**1:45:24 PM** Sen. Book
**1:45:47 PM** Appearances: Chris Nuland, Lobbyist, Florida Chapter, American College of Physicians (waives in opposition to the bill)
**1:45:59 PM** Jake Farmer, Director of Government Affairs, Florida Retail Federation (waives in support of the bill)
**1:46:07 PM** Jeff Scott, Lobbyist, Florida Medical Association (waives in opposition to the bill)
**1:46:15 PM** Steve Winn, Executive Director, Florida Osteopathic Medical Association (waives in opposition to the bill)
**1:46:27 PM** Diego Echeverri, Legislative Liaison, Americans For Prosperity (waives in support of the bill)
**1:46:37 PM** Brewster Bevis, Senior Vice-President, Associated Industries of Florida (waives in support of the bill)
**1:46:46 PM** Michael Jackson, Executive Vice-President & CEO, Florida Pharmacy Association (speaks in support of the bill)
**1:49:22 PM** Sen. Book
**1:49:54 PM** M. Jackson
**1:50:07 PM** Sen. Book
**1:50:26 PM** M. Jackson
**1:51:02 PM** Sen. Book
**1:51:41 PM** M. Jackson
**1:52:36 PM** Sen. Rouson
**1:53:07 PM** M. Jackson
**1:54:13 PM** David Poole, Director of Legislative Affairs, AIDS Healthcare Foundation (waives in support of the bill)
**1:54:25 PM** Aimee Diaz Lyon, Lobbyist, Florida Academy of Family Physicians (waives in opposition to the bill)
**1:54:34 PM** Toni Large, Lobbyist, Florida College of Emergency Physicians (waives in opposition to the bill)
**1:55:07 PM** Sen. Farmer
**1:56:42 PM** Sen. Rader
**1:59:17 PM** Sen. Passidomo
**1:59:25 PM** S 714 (temporarily postponed)
**1:59:28 PM** Sen. Hutson
**1:59:40 PM** S 1094, Consultant Pharmacists
**1:59:46 PM** Sen. Diaz
**2:00:40 PM** Appearances: Joseph Salzverg, Attorney/Lobbyist, Florida Society of Health System Pharmacists (waives in support of the bill)
**2:00:50 PM** Michael Jackson, Executive Vice-President & CEO, Florida Pharmacy Association (waives in support of the bill)
**2:01:07 PM** Jeff Scott, Lobbyist, Florida Medical Association (waives in support of the bill)
**2:01:14 PM** Aimee Diaz Lyon, Lobbyist, The Florida Academy of Family Physicians (waives in support of the bill)
**2:01:25 PM** Sen. Harrell
**2:02:03 PM** Sen. Diaz
**2:02:51 PM** S 1094 (reported favorably)
**2:03:13 PM** S 1206, Applied Behavior Analysis Services
**2:03:21 PM** Sen. Harrell
**2:05:02 PM** Appearances: Dr. Steve Coleman, Public Policy Director, Florida Association for Behavior Analysis (waives in support of the bill)
**2:05:18 PM** Marta T. "Tiki" Fiol, BCBA, Florida Association of Behavior Analysis (speaks in support of the bill)
**2:07:59 PM** Carolyn O'Connell, Owner, O'Connell Behavioral Services (speaks in support of the bill)
**2:14:12 PM** Marucci Guzman, President/Co-Founder, ABA Providers Association (waives in support of the bill)
**2:14:26 PM** Marytza Sanz, President/CEO, Santiago & Friends Family Center for Autism (waives in support of the bill)
**2:15:27 PM** Sen. Harrell
**2:16:13 PM** S 1206 (reported favorably)
**2:16:18 PM** S 122, Child Welfare
**2:16:32 PM** Sen. Rouson
**2:20:20 PM** Am. 251124
**2:20:26 PM** Sen. Rouson
**2:20:56 PM** Appearances: Victoria Zepp, Chief Policy Officer, Florida Coalition for Children (waives in support of the

amendment)
**2:21:06 PM** Alan Abramowitz, Executive Director, Statewide Guardian ad Litem Program (waives in support of the amendment)
**2:21:20 PM** Am. 251124 (adopted)
**2:21:27 PM** Am. 172158
**2:21:34 PM** Sen. Harrell
**2:21:50 PM** Appearances: V. Zepp (waives in support of the amendment)
**2:22:09 PM** Am. 172158 (adopted)
**2:22:13 PM** Am. 617230
**2:22:18 PM** Sen. Rouson
**2:22:44 PM** Sen. Harrell
**2:23:19 PM** Sen. Rouson
**2:23:39 PM** Sen. Harrell
**2:25:11 PM** Appearances: V. Zepp (waives in support of the bill)
**2:25:25 PM** Sen. Rouson
**2:25:35 PM** Am. 617230 (adopted)
**2:25:38 PM** Am. 522422
**2:25:43 PM** Sen. Rouson
**2:26:10 PM** Appearances: Neal McGarry, CEO, Florida Certification Board (waives in support of the amendment)
**2:26:30 PM** V. Zepp (speaks in support of the amendment)
**2:27:25 PM** Am. 522422 (adopted)
**2:27:27 PM** Am. 412980
**2:27:33 PM** Sen. Rouson
**2:28:00 PM** Am. 412980 (adopted)
**2:28:07 PM** Am. 894626
**2:28:13 PM** Sen. Rouson
**2:28:35 PM** Am. 894626 (adopted)
**2:28:41 PM** Am. 409736
**2:28:45 PM** Sen. Rouson
**2:29:12 PM** Appearances: Slater Bayliss, Lobbyist, Eckerd Connects (waives in support of the amendment)
**2:29:30 PM** Am. 409736 (adopted)
**2:29:31 PM** S 122 (cont.)
**2:29:36 PM** Appearances: S. Bayliss (waives in support of the bill)
**2:29:41 PM** Barney Bishop III, CEO, Florida Smart Justice Alliance (waives in support of the bill)
**2:29:56 PM** Jordan Reed, Legislative Intern, National Association of Social Workers Florida (waives in support of the bill)
**2:30:16 PM** Sen. Hooper
**2:32:11 PM** Sen. Rouson
**2:32:37 PM** S 122 (reported favorably)
**2:33:55 PM** S 926, Health Care Practitioner Licensure
**2:34:03 PM** Sen. Harrell
**2:36:10 PM** Appearances: Ivonne Fernandez, Associate State Director, AARP (waives in support of bill)
**2:36:43 PM** Sen. Harrell
**2:37:20 PM** S 926 (reported favorably)
**2:37:25 PM** S 714 (cont.)
**2:37:37 PM** Sen. Hutson
**2:38:08 PM** S 714 (reported favorably)
**2:38:31 PM** Sen. Harrell (Chair)
**2:38:40 PM** S 1726, Agency for Health Care Administration
**2:38:46 PM** Sen. Bean
**2:39:54 PM** Am. 441796
**2:41:06 PM** Sen. Bean
**2:47:13 PM** Am. 860528
**2:47:30 PM** Sen. Bean
**2:48:13 PM** Am. 860528 (adopted)
**2:48:20 PM** Am. 127166
**2:48:25 PM** Sen. Bean
**2:49:11 PM** Am. 127166 (adopted)
**2:49:18 PM** Am. 283312
**2:49:25 PM** Sen. Rader
**2:50:24 PM** Sen. Bean
**2:51:53 PM** Am. 283312 (withdrawn)

**2:52:02 PM** Am. 588700
**2:52:12 PM** Sen. Rader
**2:53:33 PM** Sen. Bean
**2:54:14 PM** Am. 588700 (withdrawn)
**2:55:25 PM** Am. 441796 (cont.)
**2:55:47 PM** Am. 441796 (adopted)
**2:55:50 PM** S 1726 (cont.)
**2:55:59 PM** Appearances: Dr. Steve Coleman, Public Policy Director, Florida Association for Behavior Analysis (waives in support of the bill)
**2:56:09 PM** Cliff Bauer, Vice-President, Government Relations, Miami Jewish Health (waives in support of the bill)
**2:56:31 PM** Sen. Diaz
**2:57:08 PM** Sen. Bean
**2:58:51 PM** S 1726 (reported favorably)
**2:59:00 PM** Sen. Bean (Chair)
**2:59:14 PM** Sen. Rouson
**2:59:19 PM** Sen. Bean
**2:59:52 PM** Sen. Diaz