Tab 1	CS/SB 00043)			on (CO-INTRODUCER	S) Berman, Hooper, Book, Rader; (Co	ompare to CS/H
251124	A	S	RCS	AHS, Rouson	Delete L.179 - 221:	02/25 03:42 PM
172158	А	S	RCS	AHS, Harrell	Delete L.351:	02/25 03:42 PM
617230	А	S	RCS	AHS, Harrell	Delete L.364 - 370.	02/25 03:42 PM
522422	А	S	RCS	AHS, Rouson	Delete L.371 - 509:	02/25 03:42 PM
412980	А	S	RCS	AHS, Rouson	Delete L.608 - 610:	02/25 03:42 PM
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409736	А	S	RCS	AHS, Rouson	btw L.733 - 734:	02/25 03:42 PM
Tab 2	CS/SB	714 by	y HP, Huts	on; (Compare to CS/H (00389) Testing for and Treatment of Influe	enza
Tab 3	SB 926	5 by Ha	nrrell; (Con	npare to H 00077) Health	n Care Practitioner Licensure	
Tab 4	CS/SB	1094	by HP, Dia	z; (Similar to CS/CS/H 0	0599) Consultant Pharmacists	
Tab 5	CS/SB	1206	by HP, Ha i	r rell ; (Compare to 1ST E	NG/H 00575) Applied Behavior Analysis S	ervices
Tab 6	-		by HP, Bei Licenses	man (CO-INTRODUCI	ERS) Rodriguez; (Compare to CS/CS/CS,	/H 00713) Health
Tab 7	-		by BI, Wri rug Coverag	je	RS) Harrell, Rodriguez, Perry ; (Compared)	re to CS/H 07045)
636790	А	S	RCS	AHS, Wright	Delete L.210 - 508:	02/25 04:03 PM
Tab 8	CS/SB	1544	by HP, Alb	ritton; (Identical to CS/	H 01373) Long-term Care	
Tab 9	CS/SB	1726	by HP, Be a	an; (Similar to CS/CS/H (00731) Agency for Health Care Administra	tion

Tab 9	CS/SB	5 1/26 C	у нр, і	Bean; (Similar to CS/CS/H 00/31) Ag	gency for Health Care Administration	n
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

TIME:	Tuesday, February 25, 2020 1:00—4:00 p.m. <i>Pat Thomas Committee Room,</i> 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 Children, Families, and Elder Affairs / Rouson (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. CF 12/10/2019 Temporarily Postponed CF 01/21/2020 Fav/CS AHS 02/25/2020 Fav/CS AP	Fav/CS Yeas 10 Nays 0
2	CS/SB 714 Health Policy / Hutson (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. HP 02/18/2020 Fav/CS AHS 02/25/2020 Favorable AP	Favorable Yeas 6 Nays 2

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services Tuesday, February 25, 2020, 1:00—4:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	SB 926 Harrell (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. HP 01/28/2020 Favorable 	Favorable Yeas 9 Nays 0
		AHS 02/25/2020 Favorable AP	
4	CS/SB 1094 Health Policy / Diaz (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. HP 02/11/2020 Fav/CS AHS 02/25/2020 Favorable AP	Favorable Yeas 10 Nays 0
5	CS/SB 1206 Health Policy / Harrell (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. HP 02/04/2020 Fav/CS AHS 02/25/2020 Favorable AP	Favorable Yeas 10 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services Tuesday, February 25, 2020, 1:00—4:00 p.m.

ТАВ	BILL NO. and INTRODUCER	BILL DESCRIPTION and LL NO. and INTRODUCER SENATE COMMITTEE ACTIONS	
6	CS/SB 1296 Health Policy / Berman (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.	Favorable Yeas 10 Nays 0
		HP 01/14/2020 Fav/CS AHS 02/25/2020 Favorable AP	
7	CS/SB 1338 Banking and Insurance / Wright (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. BI 01/21/2020 Not Considered BI 01/28/2020 Fav/CS AHS 02/25/2020 Fav/CS	Fav/CS Yeas 10 Nays 0
8	CS/SB 1544 Health Policy / Albritton (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. HP 02/04/2020 Fav/CS AHS 02/25/2020 Favorable AP	Favorable Yeas 10 Nays 0
9	CS/SB 1726 Health Policy / Bean (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. HP 01/28/2020 Fav/CS AHS 02/25/2020 Fav/CS AP	Fav/CS Yeas 8 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services Tuesday, February 25, 2020, 1:00—4:00 p.m.

		BILL DESCRIPTION and	
TAB	BILL NO. and INTRODUCER	SENATE COMMITTEE ACTIONS	COMMITTEE ACTION

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.)

	PCS/CS/SB 122 (603180)					
INTRODUCER:	Appropriations Subcommittee on H					
]	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:					
ANALYS	ST STAFF DIRECTOR	REFERENCE	ACTION			
Preston	Hendon	CF	Fav/CS			
Sneed	Kidd	AHS	Recommend: Fav/CS			
		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 <u>http://www.dcf.state.fl.us/newsroom/docs/Belliveau%20Special%20Review%202018-632408.pdf</u>. (Last visited November 15, 2019).

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 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 syndrome⁶; 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

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: <u>https://www.ncbi.nlm.nih.gov/books/NBK499836/</u> (last visited February 24, 2020).

⁷ James E. Lewis, Ph.D., *Neuropsychological Evaluations of Children and Adults in Child Welfare Cases*, available at: <u>http://centervideo.forest.usf.edu/clsneuropsych/start.html</u> (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 twoyear 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.

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 inservice 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.

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



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

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.

-Varry & Pouson

Senator Darryl Ervin Rouson Florida Senate, District 19

	THE FLORIDA SENATE	
AP	PEARANCE RECO	RD
2/25/28 (Deliver BOTH copies of this	s form to the Senator or Senate Professional S	taff conducting the meeting)
Meeting Date		Bill Number (if applicable)
Topic Child Welfare		Amendment Barcode (if applicable)
Name Victoria Zepp		
Job Title Chief Polica	Ofer	cala 1100
Address 317. E. Park	Are	Phone 800/524 1102
Street TZH 4	Z 3230/	Email Victoria Childrenorg
City	State Zip	
Speaking: For Against Info		peaking: 🖉 In Support 🔄 Against
Representing <u>A Coal</u>	itim for Chil	ir will read this information into the record.)
Appearing at request of Chair: Yes	No Lobbyist regist	ered 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.

THE FLORIDA SENATE APPEARANCE RECORD

2/24/20	(Deliver BOTH cop	ies of this form to the Senator c	or Senate Professional S	taff conducting the meeting	122
Meeting Date					Bill Number (if applicable) 251124
Topic Child Welfar	e			Ame	ndment Barcode (if applicable)
Name Alan Abramo	owitz			a	
Job Title Executive	Director			c.	
Address 600 S. Ca	lhoun St.			Phone 850.24	1.3232
<i>Street</i> Tallahasse	90	Florda	32311	Email alan.abra	amowitz@gal.fl.gov
<i>City</i> Speaking: For	Against	State		peaking: In s ir will read this infor	Support Against mation into the record.)
Representing	Statewide Guar	dian ad Litem Progr	am		
Appearing at reque	st of Chair:	Yes 🖌 No	Lobbyist regist	ered with Legisla	ature: 🖌 Yes 🗌 No
While it is a Senate tra meeting. Those who do	dition to encourag speak may be as	e public testimony, time sked to limit their remark	may not permit al ks so that as many	l persons wishing to persons as possibl	speak to be heard at this e can be heard.
This form is part of th	e public record	for this meeting.			S-001 (10/14/14)

THE FLORIDA SENATE	
2/25 (Deliver BOTH copies of this form to the Senator or Senate Professional S	
Meeting Date	Bill Number (if applicable)
Topic Child Welfare	Amendment Barcode (if applicable)
Name VICTORIA ZEPP	
Job Title Chief Polya Of	/
Address 317 2. Mark Ave	Phone 80/5761-//02
Street FL 32381 City State Zip	Email Com Chelling
	peaking: In Support Against air will read this information into the record.)
Representing <u>FCC</u>	
Appearing at request of Chair: Yes No Lobbyist regis	tered 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.

THE FLORIDA SENATE	
APPEARANCE REC	ORD
(Deliver BOTH copies of this form to the Senator or Senate Profession	onal Staff conducting the meeting)
Meeting Date	Bill Number (if applicable)
Topic Child Welfgre	Amendment Barcode (if applicable)
Name Victoria Zepp	
Job Title Chief Policy Ofer	
Address 317-E. Park	Phone 858/561-1102
Street FL 32361	Email ictor i Cfchildren.org
City State Zip	0
	e Speaking: In Support Against Chair will read this information into the record.)
Representing FL Coalition for Child	bren /
Appearing at request of Chair: Yes No Lobbyist re	egistered 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.

THE FLORIDA SENATE APPEARANCE RECORD

2/25/2020 (Deliver BC	OTH copies of this form to the Senator	or Senate Professional S	aff conducting the meeting)	CS/SB 122
Meeting Date				Bill Number (if applicable) 522422
Topic Child Welfare Certifica	Ition		Amen	dment Barcode (if applicable
Name Neal McGarry				
Job Title CEO				
Address 1715 South Gadsde	n Street		Phone 850-222	-6314
Street Tallahassee	FL	32301	Email <u>namcgarry</u> (@flcertificationboard.org
City Speaking: For Again	State			upport Against
Representing Florida Cer	rtification Board			
Appearing at request of Chair	r: 🗌 Yes 🗹 No	Lobbyist regist	ered with Legislat	ture: 🖌 Yes 🗌 No
While it is a Senate tradition to enc meeting. Those who do speak may				

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THE FLORIDA SENATE	
APPEARANCE RECO	RD
2/25/20 (Deliver BOTH copies of this form to the Senator or Senate Professional S	Staff conducting the meeting)
Meeting Date	Bill Number (if applicable)
Topic Child We Jare	Amendment Barcode (if applicable)
Name Victoria Zepp	
Job Title Chief Policy Ofcr	
Address 317 E. Park Ave	Phone 800 561-1102
City State 3230	Email Victoria flatitura
	peaking: In Support Against air will read this information into the record.)
Representing FL Cealition for Chi	laren.
Appearing at request of Chair: Yes No Lobbyist regis	tered 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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		^{ng)} SB 122				
	eeting Date				409	Bill Number (if applicable) 9736
Topic	Jordan's Law				Ame	endment Barcode (if applicable)
Name	Slater Bayliss					
Job Tit	le Lobbyist					
Addres	s 204 S Monr	oe Street			Phone 850-2	22-8900
	Tallahassee		FL	32301	Email swb@c	ardenaspartners.com
Speakir	ng: For	7	State mation	Zip Waive Sp (The Chair		Support Against
Rep	eresenting Ecl	kerd Connects				
Appear	ing at request o	of Chair: Yes	No	Lobbyist registe	ered with Legisl	ature: 🖌 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.

THE FLORIDA SENATE APPEARANCE RECORD

25 Feb 20	(Deliver BOTH co	pies of this form to the Senator	or Senate Professional St	aff conducting the meeting)	122
Meeting Da	nte				Bill Number (if applicable)
Topic Child V	Velfare			Amend	ment Barcode (if applicable)
Name Barney	/ Bishop III				
Job Title CEC)				
Address 221	5 Thomasville Road			Phone 850.510.	9922
	hassee	FL	32308	Email barney@b	arneybishop.com
<i>City</i> Speaking:	For Against	State		beaking: 🔽 In Su	
Represent	ting Florida Smart J	ustice Alliance			
Appearing at	request of Chair:	Yes 🖌 No	Lobbyist registe	ered with Legislat	ure: 🗹 Yes 🗌 No
	ate tradition to encourag who do speak may be a				

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Topic SB122	Amendment Barcode (if applicable)
Name Jordan Reed	
Job Title Legislating intom	
Address	Phone
	Email
City State Speaking: For Against Information	Zip Waive Speaking: In Support Against (The Chair will read this information into the record.)
Representing NAIMAL ASSOCICTION	of Soyal Norkers Florida
Appearing at request of Chair: Yes No Lob	byist 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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APPEARANCE RECORD

2.25.2	2020	(Deliver BOTH co	pies of this form to the Senator	or Senate Professional S	taff conducting the meeting)	SB 122
Me	eeting Date	-			4097	Bill Number (if applicable)
Topic	Jordan's Law				Amend	ment Barcode (if applicable)
Name	Slater Bayliss					
Job Tit	le Lobbyist					
Addres		oe Street			Phone850-222	-8900
	Street Tallahassee		FL	32301	Email swb@car	denaspartners.com
Speakir	City	Against	State	Zip Waive Sj (The Chai		pport Against ation into the record.)
Rep	presenting Ec	kerd Conned	cts			
Appear	ing at request	of Chair:	Yes No	Lobbyist registe	ered with Legislati	ure: 🗹 Yes 🗌 No
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S-001 (10/14/14)

586-02427-20

2020122c1

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

1 A bill to be entitled 2 An act relating to child welfare; providing a short title; amending s. 39.202, F.S.; expanding the list of 3 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 ç trauma and brain injuries in children younger than a 10 specified age; amending s. 39.401, F.S.; authorizing 11 the parent or legal guardian of a child to request a 12 second medical evaluation of a child under certain 13 circumstances; requiring the court to consider such 14 evaluation when determining whether to remove the 15 child from the home; amending s. 39.8296, F.S.; 16 revising the membership of the curriculum committee 17 established to develop a specified training program; 18 requiring the training program to include certain 19 training relating to head trauma and brain injuries in 20 children younger than a specified age; amending s. 21 402.40, F.S.; revising legislative findings and 22 providing legislative intent; requiring the department 23 to develop and implement a specified child welfare 24 workforce development framework in collaboration with 25 other specified entities; providing requirements for 26 the department relating to workforce education 27 requirements; requiring the department to submit an 28 annual report to the Governor and the Legislature by a 29 specified date; requiring community-based care lead

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2020122c1

586-02427-20 agencies to submit a plan and timeline to the department relating to certain child welfare s

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31 department relating to certain child welfare staff by 32 a specified date; providing requirements for the 33 department related to workforce training; providing 34 legislative findings; requiring the department to 35 establish an Office of Well-Being and Support; 36 requiring the department to contract with certain 37 university-based centers to develop and coordinate the 38 implementation of a specified helpline; requiring the 39 department to submit a report on the implementation of 40 such helpline to the Governor and the Legislature on a 41 specified date; providing additional duties for thirdparty credentialing entities; requiring certain 42 43 attorneys employed by the department to complete 44 certain training by a specified date; deleting 45 definitions; deleting provisions relating to core 46 competencies and specializations; amending s. 409.988, 47 F.S.; requiring a lead agency to ensure that certain 48 individuals receive specified training relating to 49 head trauma and brain injuries in children younger 50 than a specified age; revising the types of services a 51 lead agency is required to provide; creating s. 52 943.17298, F.S.; requiring law enforcement officers to 53 complete training relating to head trauma and brain 54 injuries in children younger than a specified age as 55 part of either basic recruit training or continuing 56 training or education by a specified date; amending s. 57 1004.615, F.S.; revising the purpose of the Florida 58 Institute for Child Welfare; revising requirements for

Page 2 of 26

I.	586-02427-20 2020122c1	I.	586-02427-20 2020122c1
59	the institute; revising the contents of the annual	88	5. Licensure or approval of adoptive homes, foster homes,
60	report that the institute must provide to the Governor	89	child care facilities, facilities licensed under chapter 393,
61	and the Legislature; deleting obsolete provisions;	90	family day care homes, providers who receive school readiness
62	repealing s. 402.402, F.S., relating to child	91	funding under part VI of chapter 1002, or other homes used to
63	protection and child welfare personnel and attorneys	92	provide for the care and welfare of children;
64	employed by the department; amending ss. 409.996 and	93	6. Employment screening for caregivers in residential group
65	1009.25, F.S.; conforming provisions to changes made	94	homes; or
66	by the act; providing an effective date.	95	7. Services for victims of domestic violence when provided
67		96	by certified domestic violence centers working at the
68	Be It Enacted by the Legislature of the State of Florida:	97	department's request as case consultants or with shared clients $\underline{:}$
69		98	or
70	Section 1. This act may be cited as "Jordan's Law."	99	8. Credentialing of child welfare services staff pursuant
71	Section 2. Paragraph (a) of subsection (2) of section	100	<u>to s. 402.40</u> .
72	39.202, Florida Statutes, is amended to read:	101	
73	39.202 Confidentiality of reports and records in cases of	102	Also, employees or agents of the Department of Juvenile Justice
74	child abuse or neglect	103	responsible for the provision of services to children, pursuant
75	(2) Except as provided in subsection (4), access to such	104	to chapters 984 and 985.
76	records, excluding the name of, or other identifying information	105	Section 3. Paragraph (h) of subsection (3) of section
77	with respect to, the reporter which shall be released only as	106	39.303, Florida Statutes, is amended to read:
78	provided in subsection (5), shall be granted only to the	107	39.303 Child Protection Teams and sexual abuse treatment
79	following persons, officials, and agencies:	108	programs; services; eligible cases
80	(a) Employees, authorized agents, or contract providers of	109	(3) The Department of Health shall use and convene the
81	the department, the Department of Health, the Agency for Persons	110	Child Protection Teams to supplement the assessment and
82	with Disabilities, the Office of Early Learning, or county	111	protective supervision activities of the family safety and
83	agencies responsible for carrying out:	112	preservation program of the Department of Children and Families.
84	1. Child or adult protective investigations;	113	This section does not remove or reduce the duty and
85	2. Ongoing child or adult protective services;	114	responsibility of any person to report pursuant to this chapter
86	3. Early intervention and prevention services;	115	all suspected or actual cases of child abuse, abandonment, or
87	4. Healthy Start services;	116	neglect or sexual abuse of a child. The role of the Child
	Page 3 of 26		Page 4 of 26
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CS for SB 122

	586-02427-20 2020122c1	
117	Protection Teams is to support activities of the program and to	
118	provide services deemed by the Child Protection Teams to be	
119	necessary and appropriate to abused, abandoned, and neglected	
120	children upon referral. The specialized diagnostic assessment,	
120	evaluation, coordination, consultation, and other supportive	
121	services that a Child Protection Team must be capable of	
122	providing include, but are not limited to, the following:	
123	(h) Such training services for program and other employees	
124	of the Department of Children and Families, employees of the	
125	Department of Health, and other medical professionals as is	
120	deemed appropriate to enable them to develop and maintain their	
127		
120	professional skills and abilities in handling child abuse,	
130	abandonment, and neglect cases. The training services must	
131	include training in the recognition of and appropriate responses	
131	to head trauma and brain injury in a child under 6 years of age	
132	as required under ss. 39.8296, 402.40, and 943.17298.	
134	A Child Dustastion Mean that is avaluating a percent of modical	
134	A Child Protection Team that is evaluating a report of medical neglect and assessing the health care needs of a medically	
135		
	complex child shall consult with a physician who has experience in treating children with the same condition.	
137 138		
138 139	Section 4. Subsection (3) of section 39.401, Florida	
	Statutes, is amended to read:	
140 141	39.401 Taking a child alleged to be dependent into custody;	
141	law enforcement officers and authorized agents of the	
	department	
143	(3) If the child is taken into custody by, or is delivered	
144	to, an authorized agent of the department, the agent shall	
145	review the facts supporting the removal with an attorney	
	Page 5 of 26	
C	CODING: Words stricken are deletions; words <u>underlined</u> are additions.	

	586-02427-20 2020122c1
146	representing the department. The purpose of the review is to
147	determine whether there is probable cause for the filing of a
148	shelter petition.
149	(a) If the facts are not sufficient, the child shall
150	immediately be returned to the custody of the parent or legal
151	custodian.
152	(b) If the facts are sufficient and the child has not been
153	returned to the custody of the parent or legal custodian, the
154	department shall file the petition and schedule a hearing, and
155	the attorney representing the department shall request that a
156	shelter hearing be held within 24 hours after the removal of the
157	child. While awaiting the shelter hearing, the authorized agent
158	of the department may place the child in licensed shelter care
159	or may release the child to a parent or legal custodian or
160	responsible adult relative or the adoptive parent of the child's
161	sibling who shall be given priority consideration over a
162	licensed placement, or a responsible adult approved by the
163	department if this is in the best interests of the child.
164	Placement of a child which is not in a licensed shelter must be
165	preceded by a criminal history records check as required under
166	s. 39.0138. In addition, the department may authorize placement
167	of a housekeeper/homemaker in the home of a child alleged to be
168	dependent until the parent or legal custodian assumes care of
169	the child.
170	(c) If the decision to remove a child from the home is
171	predicated upon a medical evaluation performed by a Child
172	Protection Team pursuant to s. 39.303, the parent or legal
173	guardian of the child may request that a second, independent
174	evaluation be performed by a physician who has met the relevant
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CS for SB 122

586-02427-20 2020122c1 175 qualifications of s. 39.303(2) (b) in order to determine whether 176 the child has been the victim of abuse or neglect. The court 177 must consider this evaluation when determining whether to remove 178 a child from the home. 179 Section 5. Paragraph (b) of subsection (2) of section 180 39.8296, Florida Statutes, is amended to read: 181 39.8296 Statewide Guardian Ad Litem Office; legislative 182 findings and intent; creation; appointment of executive 183 director; duties of office.-184 (2) STATEWIDE GUARDIAN AD LITEM OFFICE.-There is created a 185 Statewide Guardian Ad Litem Office within the Justice Administrative Commission. The Justice Administrative Commission 186 shall provide administrative support and service to the office 187 188 to the extent requested by the executive director within the 189 available resources of the commission. The Statewide Guardian Ad 190 Litem Office shall not be subject to control, supervision, or 191 direction by the Justice Administrative Commission in the 192 performance of its duties, but the employees of the office shall 193 be governed by the classification plan and salary and benefits 194 plan approved by the Justice Administrative Commission. 195 (b) The Statewide Guardian Ad Litem Office shall, within 196 available resources, have oversight responsibilities for and 197 provide technical assistance to all guardian ad litem and 198 attorney ad litem programs located within the judicial circuits. 199 1. The office shall identify the resources required to 200 implement methods of collecting, reporting, and tracking 201 reliable and consistent case data. 2.02 2. The office shall review the current guardian ad litem programs in Florida and other states. 203 Page 7 of 26 CODING: Words stricken are deletions; words underlined are additions.

586-02427-20 2020122c1 204 3. The office, in consultation with local guardian ad litem 205 offices, shall develop statewide performance measures and 206 standards. 207 4. The office shall develop a guardian ad litem training 208 program. The office shall establish a curriculum committee to 209 develop a guardian ad litem the training program specified in 210 this subparagraph. The curriculum committee shall include, but 211 not be limited to, dependency judges, directors of circuit 212 guardian ad litem programs, active certified guardians ad litem, 213 a mental health professional who specializes in the treatment of 214 children, a member of a child advocacy group, a representative 215 of the Florida Coalition Against Domestic Violence, an individual with a degree in social work, and a social worker 216 217 experienced in working with victims and perpetrators of child 218 abuse. The training program must include training in the 219 recognition of and appropriate responses to head trauma and brain injury in a child under 6 years of age developed by the 220 221 Child Protection Team Program within the Department of Health. 222 5. The office shall review the various methods of funding 223 guardian ad litem programs, shall maximize the use of those funding sources to the extent possible, and shall review the 224 225 kinds of services being provided by circuit guardian ad litem 226 programs. 227 6. The office shall determine the feasibility or 228 desirability of new concepts of organization, administration, 229 financing, or service delivery designed to preserve the civil 230 and constitutional rights and fulfill other needs of dependent 231 children. 232 7. In an effort to promote normalcy and establish trust Page 8 of 26

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233	between a court-appointed volunteer guardian ad litem and a
234	child alleged to be abused, abandoned, or neglected under this
235	chapter, a guardian ad litem may transport a child. However, a
236	guardian ad litem volunteer may not be required or directed by
237	the program or a court to transport a child.
238	8. The office shall submit to the Governor, the President
239	of the Senate, the Speaker of the House of Representatives, and
240	the Chief Justice of the Supreme Court an interim report
241	describing the progress of the office in meeting the goals as
242	described in this section. The office shall submit to the
243	Governor, the President of the Senate, the Speaker of the House
244	of Representatives, and the Chief Justice of the Supreme Court a
245	proposed plan including alternatives for meeting the state's
246	guardian ad litem and attorney ad litem needs. This plan may
247	include recommendations for less than the entire state, may
248	include a phase-in system, and shall include estimates of the
249	cost of each of the alternatives. Each year the office shall
250	provide a status report and provide further recommendations to
251	address the need for guardian ad litem services and related
252	issues.
253	Section 6. Section 402.40, Florida Statutes, is amended to
254	read:
255	(Substantial rewording of section. See
256	s. 402.40, F.S., for present text.)
257	402.40 Child welfare workforce; development; training;
258	certification; well-being
259	(1) LEGISLATIVE FINDINGS AND INTENT
260	(a) The Legislature finds that positive outcomes for
261	children and families involved with the child welfare system
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262	often are attributable to the strong commitment of a well-
263	trained, highly skilled, well-resourced, and dedicated child
264	welfare workforce and that the child welfare system is only as
265	good as the individuals who conduct investigations, provide
266	services to children and families, and manage service delivery.
267	(b) The Legislature also finds that child welfare agencies
268	experience barriers to establishing and maintaining a stable,
269	effective, and diverse workforce because of issues relating to
270	recruitment, education and training, inadequate supervision,
271	retention and staff turnover, and lack of support for frontline
272	individuals.
273	(c) The Legislature further finds that, although numerous
274	initiatives have been developed to address these challenges,
275	isolated interventions often fail to yield positive results,
276	whereas implementing an integrated framework across multiple
277	domains can help child welfare agencies achieve effective
278	outcomes.
279	(d) It is the intent of the Legislature to ensure a
280	systematic approach to child welfare workforce staff development
281	and the well-being of individuals providing child welfare
282	services by establishing a uniform statewide program.
283	(2) CHILD WELFARE WORKFORCE DEVELOPMENT FRAMEWORKIn order
284	to promote competency-based, outcome-focused, and data-driven
285	approaches to workforce development, the department, in
286	collaboration with the Florida Institute for Child Welfare,
287	shall develop and implement a comprehensive child welfare
288	development workforce framework using a nationally recognized
289	model for workforce development. The framework must address, at
290	a minimum, all of the following components:
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291	(a) Recruitment and hiring.
292	(b) Education and professional preparation.
293	(c) Professional training and development.
294	(d) Supervision.
295	(e) Retention.
296	(f) Caseload and workload.
297	(g) Workforce well-being and support.
298	(h) Work-life balance and flexible scheduling.
299	(i) Agency culture and climate.
300	(3) WORKFORCE EDUCATION REQUIREMENTS
301	(a) The department shall make every effort to recruit and
302	hire qualified professional staff to serve as child protective
303	investigators and child protective investigation supervisors who
304	are qualified by their education and experience to perform
305	social work functions. The department, in collaboration with the
306	lead agencies, subcontracted provider organizations, the Florida
307	Institute for Child Welfare, and other partners in the child
308	welfare system, shall develop a protocol for screening
309	candidates for child protective positions which reflects the
310	preferences specified in subparagraphs 1., 2., and 3. The
311	following persons must be given preference in recruitment, but
312	this preference serves only as guidance and does not limit the
313	department's discretion to select the best available candidates:
314	1. Individuals with a baccalaureate degree in social work,
315	and child protective investigation supervisors with a master's
316	degree in social work, from a college or university social work
317	program accredited by the Council on Social Work Education.
318	2. Individuals with a bachelor's degree or a master's
319	degree in psychology, sociology, counseling, special education,
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320	education, human development, child development, family
321	development, marriage and family therapy, or nursing.
322	3. Individuals with baccalaureate degrees who have a
323	combination of directly relevant work and volunteer experience,
324	preferably in a public service field related to children's
325	services, which demonstrates critical thinking skills, formal
326	assessment processes, communication skills, problem solving, and
327	empathy; a commitment to helping children and families; a
328	capacity to work as part of a team; an interest in continuous
329	development of skills and knowledge; and sufficient personal
330	strength and resilience to manage competing demands and handle
331	workplace stresses.
332	(b) By each October 1, the department shall submit a report
333	on the educational qualifications, turnover, and working
334	conditions of child protective investigators and supervisors to
335	the Governor, the President of the Senate, and the Speaker of
336	the House of Representatives.
337	(c) By January 1, 2021, the community-based care lead
338	agencies shall submit to the department a plan and timeline for
339	recruiting and hiring child welfare staff providing care for
340	dependent children which meet the same educational requirements
341	as required for child protective investigators and child
342	protective investigation supervisors under this subsection. The
343	plan and timeline must include the same recruiting and hiring
344	requirements for child welfare staff employed by subcontractors.
345	(4) WORKFORCE TRAINING
346	(a) In order to enable the state to recruit and retain a
347	gualified and diverse child welfare workforce that is well-
348	trained, well-supervised, and well-supported, the department
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586-02427-20 2020122c1 349 shall establish a program for a comprehensive system to provide 350 both preservice and inservice child welfare competency-based 351 training that all child welfare staff, including all staff 352 providing care for dependent children employed by a community-353 based care lead agency or by a subcontractor of such agency, are 354 required to participate in and successfully complete, 355 appropriate to their areas of responsibility. Such program must 356 include training in the recognition of and appropriate responses 357 to head trauma and brain injury in a child under 6 years of age, 358 which must be developed by the Child Protection Team Program 359 within the Department of Health. 360 (b) A community-based care lead agency may develop additional training for persons delivering child welfare 361 362 services in the agency's service area if the curriculum does not 363 conflict with training required in paragraph (a). (c) By October 1, 2021, the department shall establish, 364 365 maintain, and oversee the operation of at least one regional child welfare professional development center in this state. The 366 367 department shall determine the number and location of, and the 368 timeframe for establishing, additional development centers and 369 shall contract for the operation of the centers with a public 370 postsecondary institution pursuant to s. 402.7305. 371 (5) WORKFORCE WELL-BEING AND SUPPORT.-The Legislature finds 372 that vicarious trauma, burnout, and lack of self-care can 373 challenge all first responders, including child welfare 374 professionals. First responders who care for others often need 375 peer counseling, crisis support, and other resilience-building 376 services to normalize issues and promote retention. The 377 Legislature further finds that these activities are best

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378	provided by those with shared life experiences who may provide
379	assistance that traditional mental health or employee assistance
380	programs are unable to provide.
381	(a) The department shall establish an Office of Well-Being
382	and Support.
383	(b) The department shall contract with one or more
384	university-based centers that have expertise in behavioral
385	health to develop and coordinate the implementation of a
386	helpline that is operational 24 hours per day and 7 days a week,
387	staffed by former child welfare supervisors and caseworkers and
388	child protective investigators, and reflective of the nationally
389	recognized best practice reciprocal peer support model. The
390	helpline must be capable of providing peer support, telephone
391	assessment, and referral services.
392	(c) The department shall submit a report providing an
393	update on the activities of the office and implementation of the
394	helpline to the Governor, the President of the Senate, and the
395	Speaker of the House of Representatives on December 1, 2020.
396	(6) WORKFORCE CERTIFICATIONThe department shall approve
397	one or more third-party credentialing entities for the purpose
398	of developing and administering child welfare certification
399	programs for persons who provide child welfare services. A
400	third-party credentialing entity shall request such approval in
401	writing from the department. In order to obtain approval, the
402	third-party credentialing entity must:
403	(a) Establish professional requirements and standards that
404	applicants must achieve in order to obtain a child welfare
405	certification and to maintain such certification.
406	(b) Develop and apply core competencies and examination
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1	586-02427-20 2020122c:
407	instruments according to nationally recognized certification and
408	psychometric standards.
409	(c) Maintain a professional code of ethics and a
410	disciplinary process that apply to all persons holding child
411	welfare certification.
412	(d) Maintain a database, accessible to the public, of all
413	persons holding child welfare certification, including any
414	history of ethical violations.
415	(e) Require annual continuing education for persons holding
416	child welfare certification and require certified professionals
417	to comply with the training requirements in subsection (4) as a
418	condition of renewal or initial certification. The third-party
419	credentialing entity shall track and report compliance with this
420	section to the department on an annual basis.
421	(f) Administer a continuing education provider program to
422	ensure that only qualified providers offer continuing education
423	opportunities for certificateholders.
424	(g) All certified child welfare professionals must follow
425	the requirements of the third-party credentialing entities code
426	of ethical and professional conduct and disciplinary procedures.
427	1. The department, community based care lead agencies,
428	sheriff offices and their contracted providers shall report all
429	allegations of suspected or known violations of ethical or
430	professional misconduct standards to the department approved
431	third-party credentialing entity, including all allegations made
432	to the department's Office of Inspector General on certified
433	personnel.
434	2. The third-party credentialing entity shall review all
435	case records involving the death of a child or other critical
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436	incident to ensure compliance with the third-party credentialing
437	entity's published code of ethical and professional conduct and
438	disciplinary procedures.
439	3. The department shall provide the third-party
440	credentialing entity with all reports necessary to conduct a
441	thorough investigation on all certified child welfare service
442	providers involved with the case.
443	4. The third-party credentialing entity shall immediately
444	suspend the certification of all certified individuals involved
445	in the case pending the results of the initial review of the
446	certified professional's role and performance as it relates to
447	the case circumstance.
448	5. The department or sub-contracted employer of the
449	certified staff must immediately remove the individual from
450	their duties that require certification as a condition of
451	employment until the initial review is complete and the third-
452	party credentialing entity determines if an ethics case is
453	warranted.
454	6. Any decision by a department approved credentialing
455	entity to deny, revoke, or suspend a certification, or otherwise
456	impose sanctions on an individual who is certified, is
457	reviewable by the department. Upon receiving an adverse
458	determination, the person aggrieved may request an
459	administrative hearing pursuant to ss. 120.569 and 120.57(1)
460	within 30 days after completing any appeals process offered by
461	the credentialing entity or the department, as applicable.
462	7. The third-party credentialing entity shall track and
463	report compliance with this subsection to the department.
464	(h) Maintain an advisory committee, including
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465	representatives from each region of the department, each
466	sheriff's office providing child protective services, and each
467	community-based care lead agency, who shall be appointed by the
468	organization they represent. The third-party credentialing
469	entity may appoint additional members to the advisory committee.
470	(7) CHILD WELFARE TRAINING TRUST FUND
471	(a) There is created within the State Treasury a Child
472	Welfare Training Trust Fund to be used by the Department of
473	Children and Families for the purpose of funding the
474	professional development of persons providing child welfare
475	services.
476	(b) One dollar from every noncriminal traffic infraction
477	collected pursuant to s. 318.14(10)(b) or s. 318.18 shall be
478	deposited into the Child Welfare Training Trust Fund.
479	(c) In addition to the funds generated by paragraph (b),
480	the trust fund shall receive funds generated from an additional
481	fee on birth certificates and dissolution of marriage filings,
482	as specified in ss. 382.0255 and 28.101, respectively, and may
483	receive funds from any other public or private source.
484	(d) Funds that are not expended by the end of the budget
485	cycle or through a supplemental budget approved by the
486	department shall revert to the trust fund.
487	(8) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD
488	WELFARE CASESWith the exception of attorneys hired after July
489	1, 2014, but before July 1, 2020, who shall complete the
490	training required under this subsection by January 31, 2021,
491	attorneys hired by the department on or after July 1, 2014,
492	whose primary responsibility is representing the department in
493	child welfare cases shall receive training within the first 6
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494	months of employment in:
495	(a) The dependency court process, including the attorney's
496	role in preparing and reviewing documents prepared for
497	dependency court for accuracy and completeness;
498	(b) Preparing and presenting child welfare cases, including
499	at least 1 week of shadowing an experienced children's legal
500	services attorney who is preparing and presenting cases;
501	(c) Safety assessment, safety decisionmaking tools, and
502	safety plans;
503	(d) Developing information presented by investigators and
504	case managers to support decisionmaking in the best interest of
505	children; and
506	(e) The experiences and techniques of case managers and
507	investigators, including shadowing an experienced child
508	protective investigator and an experienced case manager for at
509	least 8 hours.
510	(8) ADOPTION OF RULES The department shall adopt rules
511	necessary to administer this section.
512	Section 7. Paragraph (f) of subsection (1) and subsection
513	(3) of section 409.988, Florida Statutes, is amended to read:
514	409.988 Lead agency duties; general provisions
515	(1) DUTIESA lead agency:
516	(f) Shall ensure that all individuals providing care for
517	dependent children participate in and successfully complete the
518	program of receive appropriate training relevant to the
519	individual's area of responsibility and meet the minimum
520	employment standards established by the department pursuant to
521	s. 402.40. The training curriculum must include training in the
522	recognition of and appropriate responses to head trauma and

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523	brain injury in a child under 6 years of age developed by the	
524	Child Protection Team Program within the Department of Health.	
525	(3) SERVICESA lead agency must provide dependent children	
526	with services that are supported by research or that are	
527	recognized as best practices in the child welfare field. The	
528	agency shall give priority to the use of services that are	
529	evidence-based and trauma-informed and may also provide other	
530	innovative services, including, but not limited to, family-	
531	centered and cognitive-behavioral interventions designed to	
532	mitigate out-of-home placements and intensive family	
533	reunification services that combine child welfare and mental	
534	health services for families with dependent children under 6	
535	years of age.	
536	Section 8. Section 943.17298, Florida Statutes, is created	
537	to read:	
538	943.17298 Training in the recognition of and responses to	
539	head trauma and brain injuryEach law enforcement officer must	
540	successfully complete training on the subject of the recognition	
541	of and appropriate responses to head trauma and brain injury in	
542	a child under 6 years of age developed by the Child Protection	
543	Team Program within the Department of Health to aid an officer	
544	in the detection of head trauma and brain injury due to child	
545	abuse. Such training must be completed as part of the basic	
546	recruit training for a law enforcement officer, as required	
547	under s. 943.13(9), or as a part of continuing training or	
548	education required under s. 943.135(1), before July 1, 2022.	
549	Section 9. Section 1004.615, Florida Statutes, is amended	
550	to read:	
551	1004.615 Florida Institute for Child Welfare	
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552	(1) There is established the Florida Institute for Child
553	Welfare within the Florida State University College of Social
554	Work. The purpose of the institute is to advance the well-being
555	of children and families who are involved with, or at risk of
556	becoming involved with, the child welfare system by facilitating
557	and supporting statewide partnerships to develop competency-
558	based education, training, and support to prepare a diverse
559	group of social work professionals for careers in child welfare
560	by improving the performance of child protection and child
561	welfare services through research, policy analysis, evaluation,
562	and leadership development. The institute shall consist of a
563	consortium of public and private universities offering degrees
564	in social work and shall be housed within the Florida State
565	University College of Social Work.
566	(2) Using such resources as authorized in the General
567	Appropriations Act, the Department of Children and Families
568	shall $\underline{\text{collaborate}}$ $\underline{\text{contract}}$ with the institute for performance of
569	the duties described in subsection $(3)$ $(4)$ using state
570	appropriations, public and private grants, and other resources
571	obtained by the institute.
572	(3) In order to increase and retain a higher percentage of
573	professionally educated social workers in the child welfare
574	system and serve as a statewide resource for child welfare
575	workforce education and training, the institute, in
576	collaboration with the Department of Children and Families,
577	shall:
578	(a) Design and disseminate a continuum of social work
579	education and training which emphasizes child welfare workforce
580	stabilization and professionalization by aligning social work
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curriculum and training with critical practice skills pursuant	610 Children and Families pursuant to s. 4	
to s. 402.40.	611 work with the department, sheriffs pro	widing child protective
(b) Identify methods to promote continuing professional	612 investigative services, community-base	d care lead agencies,
development and systems of workplace support for existing child	613 community-based care provider organiza	_
welfare staff.	614 the Department of Juvenile Justice, th	<del>e Florida Coalition</del>
(c) Develop a best practice model for providing feedback on	615 Against Domestic Violence, and other p	artners who contribute to
curriculum to social work programs and for ensuring that interns	616 and participate in providing child pro	tection and child welfare
who will be entering the child welfare profession are well-	617 services.	
supervised by university personnel during their internships.	618 (4) The institute shall:	
(d) Create a Title IV-E program designed to provide	619 (a) Maintain a program of researc	h which contributes to
professional education and monetary support to undergraduate and	620 scientific knowledge and informs both	policy and practice
graduate social work students who intend to pursue or continue a	621 related to child safety, permanency, a	nd child and family well-
career in child welfare. Goals of the program should include:	622 being.	
1. Increasing the number of individuals in the child	623 (b) Advise the department and oth	er organizations
welfare workforce who have a bachelor's degree or master's	624 participating in the child protection	and child welfare system
degree in social work.	625 regarding scientific evidence on polic	
2. Prioritizing the enrollment of current child welfare	626 child safety, permanency, and child ar	d family well-being.
staff employed by the state.	627 (c) Provide advice regarding mana	gement practices and
3. Prioritizing the enrollment of students who reflect the	628 administrative processes used by the d	lepartment and other
diversity of the state's child welfare population.	629 organizations participating in the chi	.ld protection and child
4. Providing specific program support through the provision	630 welfare system and recommend improvement	ents that reduce
of specialized competency-based child welfare curriculum and	631 burdensome, ineffective requirements f	or frontline staff and
monetary support to students.	632 their supervisors while enhancing thei	<del>r ability to effectively.</del>
(e) Engage in evaluation and dissemination of evidence-	633 investigate, analyze, problem solve, a	nd supervise.
based and promising practices in child welfare and build high-	634 (d) Assess the performance of chi	.ld protection and child
quality evaluation into new program models and pilots.	635 welfare services based on specific out	come measures.
	636 (e) Evaluate the scope and effect	iveness of preservice and
The institute shall also provide consultation on the creation of	637 inservice training for child protection	»n and child welfare
the Office of Well-Being and Support within the Department of	638 employees and advise and assist the de	partment in efforts to
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improve such training.	668 holds a faculty appointment in the Florida State University
(f) Assess the readiness of social work graduates to assume	669 College of Social Work. The institute shall be administered by
job responsibilities in the child protection and child welfare	670 the director, and the director's office shall be located at the
system and identify gaps in education which can be addressed	671 Florida State University. The director is responsible for
through the modification of curricula or the establishment of	672 overall management of the institute and for developing and
industry certifications.	673 executing the work of the institute consistent with the
(g) Develop and maintain a program of professional support	674 responsibilities in subsection $(3)$ $(4)$ . The director shall
including training courses and consulting services that assist	675 engage individuals in other state universities with accredited
both individuals and organizations in implementing adaptive and	676 colleges of social work to participate in the institute.
resilient responses to workplace stress.	677 Individuals from other university programs relevant to the
(h) Participate in the department's critical incident	678 institute's work, including, but not limited to, economics,
response team, assist in the preparation of reports about such	679 management, law, medicine, and education, may also be invited by
incidents, and support the committee review of reports and	680 the director to contribute to the institute. The universities
development of recommendations.	681 participating in the institute shall provide facilities, staff,
(i) Identify effective policies and promising practices,	682 and other resources to the institute to establish statewide
including, but not limited to, innovations in coordination	683 access to institute programs and services.
between entities participating in the child protection and child	684 (5)(6) By each October 1 of each year, the institute shall
welfare system, data analytics, working with the local	685 provide a written report to the Governor, the President of the
community, and management of human service organizations, and	686 Senate, and the Speaker of the House of Representatives which
communicate these findings to the department and other	687 outlines its activities in the preceding year, reports
organizations participating in the child protection and child	688 significant research findings, as well as results of other
welfare system.	689 programs, and provides specific recommendations for improving
(j) Develop a definition of a child or family at high risk	690 education, training, and support for individuals in the child
of abuse or neglect. Such a definition must consider	691 welfare workforce child protection and child welfare services.
characteristics associated with a greater probability of abuse	692 (a) The institute shall include an evaluation of the
and neglect.	693 results of the educational and training requirements for child
(5) The President of the Florida State University shall	694 protection and child welfare personnel established under this
appoint a director of the institute. The director must be a	695 act and recommendations for application of the results to child
child welfare professional with a degree in social work who	696 protection personnel employed by sheriff's offices providing
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697	child protection services in its report due October 1, 2017.
698	(b) The institute shall include an evaluation of the
699	effects of the other provisions of this act and recommendations
700	for improvements in child protection and child welfare services
701	in its report due October 1, 2018.
702	(7) The institute shall submit a report with
703	recommendations for improving the state's child welfare system.
704	The report shall address topics including, but not limited to,
705	enhancing working relationships between the entities involved in
706	the child protection and child welfare system, identification of
707	and replication of best practices, reducing paperwork,
708	increasing the retention of child protective investigators and
709	case managers, and caring for medically complex children within
710	the child welfare system, with the goal of allowing the child to
711	remain in the least restrictive and most nurturing environment.
712	The institute shall submit an interim report by February 1,
713	2015, and final report by October 1, 2015, to the Governor, the
714	President of the Senate, and the Speaker of the House of
715	Representatives.
716	Section 10. Section 402.402, Florida Statutes, is
717	repealed.
718	Section 11. Subsection (9) of section 409.996, Florida
719	Statutes, is amended to read:
720	409.996 Duties of the Department of Children and Families
721	The department shall contract for the delivery, administration,
722	or management of care for children in the child protection and
723	child welfare system. In doing so, the department retains
724	responsibility for the quality of contracted services and
725	programs and shall ensure that services are delivered in
	Page 25 of 26
c	CODING: Words stricken are deletions; words underlined are additions.

586-02427-20 2020122c1 726 accordance with applicable federal and state statutes and 727 regulations. 728 (9) The department shall develop, in cooperation with the 729 lead agencies, a third-party credentialing entity approved pursuant to s. 402.40(3), and the Florida Institute for Child 730 731 Welfare established pursuant to s. 1004.615, a standardized competency-based curriculum for certification training for child 732 733 protection staff. Section 12. Paragraph (h) of subsection (1) of section 734 735 1009.25, Florida Statutes, is amended to read: 736 1009.25 Fee exemptions.-(1) The following students are exempt from the payment of 737 tuition and fees, including lab fees, at a school district that 738 739 provides workforce education programs, Florida College System 740 institution, or state university: 741 (h) Pursuant to s. 402.403, child protection and child welfare personnel as defined in s. 402.402 who are enrolled in 742 743 an accredited bachelor's degree or master's degree in social 744 work program, provided that the student attains at least a grade 745 of "B" in all courses for which tuition and fees are exempted. 746 Section 13. This act shall take effect July 1, 2020.

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 179 - 221 and insert: Section 5. Section 39.820, Florida Statutes, is amended to read:

39.820 Definitions.—As used in this <u>chapter</u> <del>part</del>, the term: (1) "Guardian ad litem" as referred to in any civil or criminal proceeding includes the following: <u>the Statewide</u> Guardian Ad Litem Office, which includes circuit <del>a certified</del>

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11 guardian ad litem programs; program, a duly certified volunteer, 12 a staff member, a staff attorney, a contract attorney, or a 13 certified pro bono attorney working on behalf of a guardian ad 14 litem or the program; staff members of a program office; a 15 court-appointed attorney; or a responsible adult who is appointed by the court to represent the best interests of a 16 17 child in a proceeding as provided for by law, including, but not 18 limited to, this chapter, who is a party to any judicial 19 proceeding as a representative of the child, and who serves 20 until discharged by the court.

(2) "Guardian advocate" means a person appointed by the court to act on behalf of a drug dependent newborn <u>under</u> <del>pursuant to the provisions of</del> 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.-

29 (2) STATEWIDE GUARDIAN AD LITEM OFFICE.-There is created a 30 Statewide Guardian Ad Litem Office within the Justice 31 Administrative Commission. The Justice Administrative Commission 32 shall provide administrative support and service to the office 33 to the extent requested by the executive director within the available resources of the commission. The Statewide Guardian Ad 34 35 Litem Office is shall not be subject to control, supervision, or 36 direction by the Justice Administrative Commission in the 37 performance of its duties, but the employees of the office are 38 shall be governed by the classification plan and salary and benefits plan approved by the Justice Administrative Commission. 39

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40 (b) The Statewide Guardian Ad Litem Office shall, within available resources, have oversight responsibilities for and 41 42 provide technical assistance to all guardian ad litem and 43 attorney ad litem programs located within the judicial circuits. 1. The office shall identify the resources required to 44 45 implement methods of collecting, reporting, and tracking reliable and consistent case data. 46 47 2. The office shall review the current quardian ad litem 48 programs in Florida and other states. 3. The office, in consultation with local guardian ad litem 49 50 offices, shall develop statewide performance measures and 51 standards. 52 4. The office shall develop a quardian ad litem training 53 program, which shall include, but not be limited to, training on 54 the recognition of and responses to head trauma and brain injury 55 in a child under 6 years of age. The office shall establish a 56 curriculum committee to develop the training program specified 57 in this subparagraph. The curriculum committee shall include, 58 but not be limited to, dependency judges, directors of circuit 59 guardian ad litem programs, active certified guardians ad litem, 60 a mental health professional who specializes in the treatment of 61 children, a member of a child advocacy group, a representative 62 of a domestic violence advocacy group the Florida Coalition 63 Against Domestic Violence, and a social worker experienced in 64 working with victims and perpetrators of child abuse. 65 66 67 And the title is amended as follows: Delete lines 15 - 20 68

603-04011-20

COMMITTEE AMENDMENT

Florida Senate - 2020 Bill No. CS for SB 122



69	and insert:
70	child from the home; amending s. 39.820, F.S.;
71	revising the definition of the terms "guardian ad
72	litem" and "guardian advocate"; amending s. 39.8296,
73	F.S.; requiring that the guardian ad litem training
74	program include training on the recognition of and
75	responses to head trauma and brain injury in specified
76	children; amending s.

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	LEGISLATIVE ACTION	
Senate		House
Comm: RCS		
02/25/2020	•	
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Appropriations Cubcommi	ttoo on Hoolth and H	
Appropriations Subcommi (Harrell) recommended t		uman Services
(Hallell) recommended (	the following:	
Senate Amendment		
Delete line 351		
Delete line 351 and insert:		
and insert:	: all child welfare s	taff, including all
	all child welfare s	taff, including all
and insert: training curricula that	all child welfare s	taff, including all
and insert: training curricula that	all child welfare s	taff, including all

House

Florida Senate - 2020 Bill No. CS for SB 122

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#### LEGISLATIVE ACTION

Senate . Comm: RCS . 02/25/2020 . .

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

#### Senate Amendment

1 2 3

Delete lines 364 - 370.

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 371 - 509 and insert: (5) WORKFORCE CERTIFICATION. - The department shall approve one or more third-party credentialing entities for the purpose

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third-party credentialing entity shall request such approval in

writing from the department. In order to obtain approval, the

of developing and administering child welfare certification programs for persons who provide child welfare services. A

11	third-party credentialing entity must:
12	(a) Establish professional requirements and standards that
13	applicants must achieve in order to obtain a child welfare
14	certification and to maintain such certification.
15	(b) Develop and apply core competencies and examination
16	instruments according to nationally recognized certification and
17	psychometric standards.
18	(c) Maintain a professional code of ethics and a
19	disciplinary process that apply to all persons holding child
20	welfare certification.
21	(d) Maintain a database, accessible to the public, of all
22	persons holding child welfare certification, including any
23	history of ethical violations.
24	(e) Require annual continuing education for persons holding
25	child welfare certification and require certified professionals
26	to comply with the training requirements in subsection (4) as a
27	condition of renewal or initial certification. The third-party
28	credentialing entity shall track and report compliance with this
29	section to the department on an annual basis.
30	(f) Administer a continuing education provider program to
31	ensure that only qualified providers offer continuing education
32	opportunities for certificateholders.
33	(g) All certified child welfare professionals must follow
34	the requirements of the third-party credentialing entities code
35	of ethical and professional conduct and disciplinary procedures.
36	1. The department, community based care lead agencies,
37	sheriff offices and their contracted providers shall report all
38	allegations of suspected or known violations of ethical or
39	professional misconduct standards to the department approved

522422

40 third-party credentialing entity, including all allegations made 41 to the department's Office of Inspector General on certified 42 personnel. 43 2. The third-party credentialing entity shall review all 44 case records involving the death of a child or other critical 45 incident to ensure compliance with the third-party credentialing 46 entity's published code of ethical and professional conduct and 47 disciplinary procedures. 48 3. The department shall provide the third-party 49 credentialing entity with all reports necessary to conduct a 50 thorough investigation on all certified child welfare service 51 providers involved with the case. 52 4. The third-party credentialing entity shall immediately 53 suspend the certification of all certified individuals involved 54 in the case pending the results of the initial review of the 55 certified professional's role and performance as it relates to 56 the case circumstance. 57 5. The department or sub-contracted employer of the 58 certified staff must immediately remove the individual from 59 their duties that require certification as a condition of 60 employment until the initial review is complete and the third-61 party credentialing entity determines if an ethics case is 62 warranted. 63 6. Any decision by a department approved credentialing 64 entity to deny, revoke, or suspend a certification, or otherwise 65 impose sanctions on an individual who is certified, is 66 reviewable by the department. Upon receiving an adverse 67 determination, the person aggrieved may request an 68 administrative hearing pursuant to ss. 120.569 and 120.57(1)

69	within 30 days after completing any appeals process offered by
70	the credentialing entity or the department, as applicable.
71	7. The third-party credentialing entity shall track and
72	report compliance with this subsection to the department.
73	(h) Maintain an advisory committee, including
74	representatives from each region of the department, each
75	sheriff's office providing child protective services, and each
76	community-based care lead agency, who shall be appointed by the
77	organization they represent. The third-party credentialing
78	entity may appoint additional members to the advisory committee.
79	(6) CHILD WELFARE TRAINING TRUST FUND
80	(a) There is created within the State Treasury a Child
81	Welfare Training Trust Fund to be used by the Department of
82	Children and Families for the purpose of funding the
83	professional development of persons providing child welfare
84	services.
85	(b) One dollar from every noncriminal traffic infraction
86	collected pursuant to s. 318.14(10)(b) or s. 318.18 shall be
87	deposited into the Child Welfare Training Trust Fund.
88	(c) In addition to the funds generated by paragraph (b),
89	the trust fund shall receive funds generated from an additional
90	fee on birth certificates and dissolution of marriage filings,
91	as specified in ss. 382.0255 and 28.101, respectively, and may
92	receive funds from any other public or private source.
93	(d) Funds that are not expended by the end of the budget
94	cycle or through a supplemental budget approved by the
95	department shall revert to the trust fund.
96	(7) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD
97	WELFARE CASESWith the exception of attorneys hired after July

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99	training required under this subsection by January 31, 2021,
100	attorneys hired by the department on or after July 1, 2014,
101	whose primary responsibility is representing the department in
102	child welfare cases shall receive training within the first 6
103	months of employment in:
104	(a) The dependency court process, including the attorney's
105	role in preparing and reviewing documents prepared for
106	dependency court for accuracy and completeness;
107	(b) Preparing and presenting child welfare cases, including
108	at least 1 week of shadowing an experienced children's legal
109	services attorney who is preparing and presenting cases;
110	(c) Safety assessment, safety decisionmaking tools, and
111	safety plans;
112	(d) Developing information presented by investigators and
113	case managers to support decisionmaking in the best interest of
114	children; and
115	(e) The experiences and techniques of case managers and
116	investigators, including shadowing an experienced child
117	protective investigator and an experienced case manager for at
118	least 8 hours.
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120	======================================
121	And the title is amended as follows:
122	Delete lines 33 - 35
123	and insert:
124	department related workforce training; providing
125	additional duties for third-

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#### LEGISLATIVE ACTION

 Senate
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 House

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

Senate Amendment

Delete lines 608 - 610

and insert:

The institute shall

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LEGISLATIVE ACTION

Senate Comm: RCS 02/25/2020 House

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

Senate Amendment (with title amendment)

Delete lines 718 - 733.

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House

Florida Senate - 2020 Bill No. CS for SB 122

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LEGISLATIVE ACTION

Senate 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.

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

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11	up to three judicial circuits in which to develop and implement
12	the program, with priority given to a circuit that has a high
13	removal rate, significant case management turnover rate, and the
14	highest numbers of children in out-of-home care or a significant
15	increase in the number of children in out-of-home care over the
16	last 3 fiscal years.
17	(b) If the program is created, it must do each of the
18	following:
19	1. Include caseloads for dependency case managers comprised
20	solely of children who are under 6 years of age, except as
21	provided in paragraph (c). The maximum caseload for a case
22	manager shall be no more than 15 children, if possible.
23	2. Include case managers who are trained specifically in:
24	a. Critical child development for children under 6 years of
25	age;
26	b. Specific practices of child care for children under 6
27	years of age;
28	c. The scope of community resources available to children
29	under 6 years of age; and
30	d. Working with a parent or caregiver and assisting him or
31	her in developing the skills necessary to care for the health,
32	safety, and well-being of a child under 6 years of age.
33	(c) If a child being served through the program has a
34	dependent sibling, the sibling may be assigned to the same case
35	manager as the child being served through the program; however,
36	each sibling counts toward the case manager's maximum caseload
37	as provided under paragraph (b).
38	(d) If the program is created, the department shall
39	evaluate the permanency, safety, and well-being of children

Page 2 of 3

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40	being served through the program and submit a report to the
41	Governor, the President of the Senate, and the Speaker of the
42	House of Representatives by October 1, 2025, detailing its
43	findings.
44	
45	===== DIRECTORY CLAUSE AMENDMENT ======
46	And the directory clause is amended as follows:
47	Delete line 719
48	and insert:
49	Statutes, is amended, and subsection (24) is added to that
50	section, to read:
51	
52	=========== T I T L E A M E N D M E N T =================================
53	And the title is amended as follows:
54	Delete line 64
55	and insert:
56	employed by the department; amending s. 409.996, F.S.;
57	conforming a provision to changes made by the act;
58	authorizing the department and certain lead agencies
59	to create and implement a program to more effectively
60	provide case management services to specified
61	children; providing criteria for selecting judicial
62	circuits for implementation of the program; specifying
63	requirements of the program; requiring the department
64	to submit a report to the Governor and the Legislature
65	by a specified date under specified conditions;
66	amending s.

603-04019-20

#### 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.)

Prepareo	a By: The Pro	oressional Staff o	of the Approp	priations Subcommi	ttee on Health	and Human Services
BILL:	CS/SB 71	4				
INTRODUCER:	RODUCER: Health Policy Committee and Senate					
SUBJECT: Testing for and Treatment of Influenza						
DATE:	February	24, 2020 _F	REVISED:			
ANAL	YST	STAFF DI	RECTOR	REFERENCE		ACTION
. Rossitto-Va Winkle	an	Brown		HP	Fav/CS	
. Howard		Kidd		AHS	Recomme	nd: Favorable
				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
  - $\circ$  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 <u>https://www.aacp.org/about-aacp</u> (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;
  - o Phenazopyridine, for urinary pain; and

- ¹⁶ See s. 465.189, F.S.
- ¹⁷ Id.

- ¹⁹ Section 465.003(13), F.S.
- ²⁰ Section 465.186, F.S.
- ²¹ Id.

¹⁵ A Class III institutional pharmacy are those pharmacies affiliated with a hospital. See s. 465.019(2)(d), F.S.

¹⁸ Section 465.1893, F.S.

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 <u>http://www.ascp.com/page/whatisacp</u> (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 medication³⁷ approved by the United States Food and Drug Administration.³⁸ To be eligible to administer such injections, a pharmacist must:³⁹

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 <a href="https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Long-Acting-Injectables">https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Long-Acting-Injectables</a> (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

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* <u>https://www.cdc.gov/flu/about/keyfacts.htm</u> (last visited Feb 13, 2020).

⁴³ Center for Disease Control and Prevention, *Influenza (Flu)*, available at <u>https://www.cdc.gov/flu/about/viruses/index.htm</u> (last visited Feb. 13, 2020).

⁴⁴ Center for Disease Control and Prevention, *Types of Influenza Viruses*, (November 18, 2019) *available at* <u>https://www.cdc.gov/flu/about/viruses/types.htm</u> (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:
  - o 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;
  - o Liver disorders; and

⁴⁶ Center for Disease Control and Prevention, *Flu Symptoms & Complications*, (September 18, 2019) *available at* <u>https://www.cdc.gov/flu/symptoms/symptoms.htm</u> (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.

⁴⁸ Center for Disease Control and Prevention, *People at High Risk For Flu Complications*, (last reviewed August 27, 2018), *available at* <u>https://www.cdc.gov/flu/highrisk/index.htm</u> (last visited Feb. 13, 2020).

⁴⁹ Center for Disease Control and Prevention, *Rapid Influenza Diagnostic Tests*, (last reviewed October 25, 2016), *available at* <u>https://www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm</u> (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 <a href="https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm">https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm</a> (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* <u>https://www.cvs.com/minuteclinic/services?WT.ac=MC-Home-Badge1-services</u> (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* <u>http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/ documents/guidelines-health-care.pdf</u> (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 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
    - 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;
  - o 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.

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

2/25/20 Meeting Date The FLORID	CE RECORD
Topic	Amendment Barcode (if applicable)
Name Chris Nuland	
Job Title	
Address 4427 Herrchel St	Phone <u>904-233-3051</u>
Street Jacksonville, P2 32210 City State	Zip Email <u>Nand law each com</u>
Speaking: For Against Information	Waive Speaking: In Support Against (The Chair will read this information into the record.)
Representing <u>Florida Chapter</u> , America	r College of Physicians
Appearing at request of Chair: Yes No	Lobbyist registered with Legislature: Ves No

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

THE FLOR	RIDA SENATE	
2-25-20 (Deliver BOTH copies of this form to the Senator	or Senate Professional Staff conducting the m	neeting) 714
Meeting Date		Bill Number (if applicable)
Topic Testing For & That Treatment	of Infivenza	Amendment Barcode (if applicable)
Name JAKE FARMER		
Job Title Director of Government Affairs		
Address 227 S Alans St	Phone	52 359 6835
Street Talahassa R City State	<u>3250</u> Email	Jake Prf. org
Speaking: For Against Information	·	In Support Against information into the record.)
Representing <u>Florida</u> Retail Feder	ation	
Appearing at request of Chair: Yes	Lobbyist registered with Leg	gislature: Yes No

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APPEARAN	<b>DA SENATE</b> <b>CE RECORD</b> Senate Professional Staff conducting the meeting) Sp 714 Bill Number (if applicable)
Topic Test = Trest	Amendment Barcode (if applicable)
Name Jeff Scott	
Job Title	
Address 1430 Piedmout Dr. E. Street	Phone <u>850</u> 224-6492
Talkkjjer FL City State	32308 Email JScotleflmedical.org
Speaking: For Against Information	Waive Speaking: In Support Against (The Chair will read this information into the record.)
Representing Florida Medical Associa	tion
Appearing at request of Chair: Yes 🔽 No	Lobbyist registered with Legislature: Yes 🗌 No

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THE FLORIDA APPEARANC 2/25/20 Meeting Date Contemporate Meeting Date	ERECORD
Topic Test and Treat	Amendment Barcode (if applicable)
Name Steve Winn	
Job Title Executive Dir.	
Address 2544 Blairstone Pines Dr	Phone 878 - 7364
Street Tallahassee FL 37. City State	2 <u>301</u> Email
Speaking: For Against Information Representing Florida Osteopathic Ma	Waive Speaking: In Support Against (The Chair will read this information into the record.)
	obbyist registered with Legislature: Yes No

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THE FLORIDA SENATE	
APPEARANCE RECO	
(Deliver BOTH copies of this form to the Senator or Senate Professional St Meeting Date	$\frac{5B}{Bill Number (if applicable)}$
Topic Festing for In Alvenza	Amendment Barcode (if applicable)
Name DIEGO ECHEVERRI "DEE-YEH-GOH	Etch-UH-VEH-REE"
Job Title Legislative Liaison	
Address 200 W College Are	Phone
TLH FL City State Zip	Email decheverrientphy.
	eaking: In Support Against r will read this information into the record.)
Representing <u>Americans</u> For Prosperity	
Appearing at request of Chair: Yes No Lobbyist register	ered 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)

714

Meeting Date			Bill Number (if applicable)
TopicTesting for and Treatment	of Influenza		Amendment Barcode (if applicable
Name Brewster Bevis			
Job Title Senior Vice President			
Address 516 N Adams St			Phone 224-7173
Street			
Tallahassee	FL	32301	Email bbevis@aif.com
City	State	Zip	
Speaking: For Against	Information		peaking: In Support Against ir will read this information into the record.)
Representing Associated Ind	ustries of Florida		
Appearing at request of Chair:	Yes 🖌 No	Lobbyist regist	ered with Legislature: 🗹 Yes 🗌 No
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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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2/25/20

S-001 (10/14/1

# 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			Bill Number (if applicable)
-	TREATMENT OF	INFLUEWZA	Amendment Barcode (if applicable)
Name Michael Jackson			
Job Title Executive Vice President a	and CEO		
Address 610 North Adams Street			Phone (850) 222-2400
Street		00004	
Tallahassee	Florida	32301	Email <u>mjackson@pharmview.com</u>
<i>City</i> Speaking: For Against	State		peaking: In Support Against ir will read this information into the record.)
Representing Florida Pharmac	y Association		
Appearing at request of Chair:	Yes 🔀 No	Lobbyist regist	ered with Legislature: 🔀 Yes 🗌 No
While it is a Canata tradition to anaquiras	a nublic testimony time	mou not normit all	persons wishing to speak to be beard at this

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.

THE FLO	RIDA SENATE	
APPEARAN	NCE RECORI	
(Deliver BOTH copies of this form to the Senato Meeting Date	r or Senate Professional Staff c	onducting the meeting) 7 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
Topic Pharmacy/Flut Test	3 Treat	Amendment Barcode (if applicable)
Name IONI Large		
Job Title		(850)
Address 215 Monroe St	P	hone 556-146
Street Tallahassee, FL City State	32308 E	mail toni @ large strategies-
Speaking: For Against Information	Waive Spea (The Chair wi	king: In Support Against In Support Against In Support In Support Against Information into the record.)
Representing Floridg College of	Emergency	Physicians
Appearing at request of Chair: Yes No	Lobbyist registere	d 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) Meeting Date Bill Number (if applicable)	nle)
Topic Testing for and treatment of Influenza Amendment Barcode (if applica	ble)
Name Himee Diaz Lyon	
Job Title	
Address 119 South Monroe Street Suite 200 Phone 850-205-900	$\infty$
Street Tallamassee PL 32301 Email ainee. diastronembelli City State Zip	<u>(m</u> .(0
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	10

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	THE FLO	rida Senate		
2020 ap- (Deliver BOTH copies	APPEARAN s of this form to the Senator	or Senate Professional St	RD aff conducting the meet	ing)
2/25/ <del>2019</del> Meeting Date				Bill Number (if applicable)
incoming Date				
Topic Prescription Drug Coverage			Am	endment Barcode (if applicable)
Name David Poole				
Job Title Director Legislative Affairs				
Address 1825 Country Club Dr			Phone 850-76	66-3323
Tallahassee	FL	32301	Email david.p	oole@aidshealth.org
City Speaking: For Against	State			Support Against formation into the record.)
Representing AIDS Healthcare F	oundation (AHF)			
Appearing at request of Chair:	Yes 🖌 No	Lobbyist regist	ered with Legis	slature: 🖌 Yes 🗌 No

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S-001 (10/14/14)

Duplicate

588-03836-20

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2020714c1

By the Committee on Health Policy; and Senator Hutson

1 A bill to be entitled 2 An act relating to the testing for and treatment of 3 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 8 ç and treat influenza and providing requirements 10 relating thereto; requiring the written protocol 11 between a pharmacist and a supervising physician to 12 contain certain information, terms, and conditions; 13 requiring the Board of Medicine, in consultation with 14 the Board of Pharmacy and the Board of Osteopathic 15 Medicine, to develop a specified certification program 16 for pharmacists within a specified timeframe; 17 requiring a pharmacist to collect a medical history 18 before testing and treating a patient; requiring a 19 pharmacy in which a pharmacist tests for and treats 20 influenza to display and distribute specified 21 information; providing limitations on the medications

#### for and treat influenza; providing that a person may Page 1 of 9

a pharmacist may administer to treat influenza;

requiring pharmacists to review certain information

for a specified purpose before testing and treating

treats influenza to maintain professional liability

recordkeeping requirements for pharmacists who test

patients; requiring a pharmacist who tests for and

insurance in a specified amount; providing

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

T	588-03836-20 20207140
30	not interfere with a physician's professional decision
31	to enter into a written protocol with a pharmacist;
32	providing that a pharmacist may not enter into a
33	written protocol under certain circumstances;
34	requiring the Board of Medicine, in consultation with
35	the Board of Pharmacy and the Board of Osteopathic
36	Medicine, to adopt rules within a specified timeframe;
37	requiring pharmacists to notify a patient's primary
38	care provider and follow up with the treated patient
39	within specified timeframes; prohibiting a pharmacist
40	from testing or treating patients under certain
41	circumstances; specifying circumstances under which a
42	physician may supervise a pharmacist under a written
43	protocol; providing a contingency on implementation;
44	providing an effective date.
45	
46 47	Be It Enacted by the Legislature of the State of Florida:
48	Section 1. Subsection (2) of section 381.0031, Florida
49	Statutes, is amended to read:
50	381.0031 Epidemiological research; report of diseases of
51	public health significance to department
52	(2) Any practitioner licensed in this state to practice
53	medicine, osteopathic medicine, chiropractic medicine,
54	naturopathy, or veterinary medicine; any licensed pharmacist
55	authorized pursuant to a written protocol to order and evaluate
56	laboratory and clinical tests; any hospital licensed under part
57	I of chapter 395; or any laboratory appropriately certified by
58	the Centers for Medicare and Medicaid Services under the federal
	Page 2 of 9

588-03836-20 2020714c1 59 Clinical Laboratory Improvement Amendments, and the federal 60 rules adopted thereunder, which diagnoses or suspects the 61 existence of a disease of public health significance shall 62 immediately report the fact to the Department of Health. 63 Section 2. Subsection (13) of section 465.003, Florida Statutes, is amended to read: 64 465.003 Definitions.-As used in this chapter, the term: 65 66 (13) "Practice of the profession of pharmacy" includes 67 compounding, dispensing, and consulting concerning contents, 68 therapeutic values, and uses of any medicinal drug; consulting 69 concerning therapeutic values and interactions of patent or 70 proprietary preparations, whether pursuant to prescriptions or 71 in the absence and entirely independent of such prescriptions or 72 orders; and conducting other pharmaceutical services. For 73 purposes of this subsection, "other pharmaceutical services" 74 means the monitoring of the patient's drug therapy and assisting 75 the patient in the management of his or her drug therapy, and 76 includes review of the patient's drug therapy and communication 77 with the patient's prescribing health care provider as licensed 78 under chapter 458, chapter 459, chapter 461, or chapter 466, or 79 similar statutory provision in another jurisdiction, or such 80 provider's agent or such other persons as specifically 81 authorized by the patient, regarding the drug therapy. However, 82 nothing in this subsection may be interpreted to permit an 83 alteration of a prescriber's directions, the diagnosis or 84 treatment of any disease, the initiation of any drug therapy, 85 the practice of medicine, or the practice of osteopathic 86 medicine, unless otherwise permitted by law. "Practice of the profession of pharmacy" also includes any other act, service, 87 Page 3 of 9

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588-03836-20 2020714c1 88 operation, research, or transaction incidental to, or forming a 89 part of, any of the foregoing acts, requiring, involving, or 90 employing the science or art of any branch of the pharmaceutical 91 profession, study, or training, and shall expressly permit a 92 pharmacist to transmit information from persons authorized to 93 prescribe medicinal drugs to their patients. The practice of the 94 profession of pharmacy also includes the administration of 95 vaccines to adults pursuant to s. 465.189, the testing for and treatment of influenza pursuant to s. 465.1895, and the 96 97 preparation of prepackaged drug products in facilities holding 98 Class III institutional pharmacy permits. Section 3. Section 465.1895, Florida Statutes, is created 99 to read: 100 101 465.1895 Testing for and treatment of influenza.-(1) A pharmacist may test for and treat influenza if all of 102 103 the following criteria are met: 104 (a) The pharmacist has entered into a written protocol with 105 a supervising physician licensed under chapter 458 or chapter 106 459, and such protocol complies with the requirements in 107 subsection (5) and the Board of Medicine's rules. 108 (b) The pharmacist uses an instrument and a waived test, as 109 that term is defined in 42 C.F.R. s. 493.2. 110 (c) The pharmacist uses a testing system that: 111 1. Provides automated readings in order to reduce user 112 subjectivity or interpretation of results. 113 2. Is capable of directly or indirectly interfacing with 114 electronic medical records systems. 115 3. Is capable of electronically reporting daily deidentified test results to the appropriate agencies. 116

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	4. Uses an instrument that incorporates both internal and
118	external controls and external calibration that show the reagent
119	and assay procedure is performing properly. External controls
120	must be used in accordance with local, state, and federal
121	regulations and accreditation requirements.
122	(d) The pharmacist is certified to test for and treat
123	influenza pursuant to a certification program approved by the
124	Board of Medicine, in consultation with the board and the Board
125	of Osteopathic Medicine. The certification program must be
126	developed and implemented within 90 days after the date upon
127	which this section becomes effective and must require that the
128	pharmacist attend, on a one-time basis, 8 hours of continuing
129	education courses approved by the Board of Medicine. The
130	continuing education curriculum must be provided by an
131	organization that is approved by the Accreditation Council for
132	Pharmacy Education to provide instructional services and must
133	include, at a minimum, point-of-care testing for influenza and
134	the safe and effective treatment of influenza.
135	(e) The pharmacist collects from the patient a full history
136	of the patient's past and present medical conditions on a form
137	adopted by the Board of Medicine by rule which allows the
138	patient to check off medical conditions from a list and add
139	other conditions that are not listed. The history must be
140	maintained as part of the patient's records in accordance with
141	subsection (3).
142	(f) The pharmacy in which a pharmacist tests for and treats
143	influenza prominently displays signage indicating that any
144	patient tested and treated at the pharmacy is advised to seek
145	followup care from his or her primary care physician or, if the
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146	patient has no primary care physician, from the pharmacist's
147	supervising physician.
148	(g) The pharmacist who tests for or treats influenza
149	provides the patient with the name and contact information for
150	the pharmacist's supervising physician and a pamphlet or
151	brochure that meets criteria established by the Board of
152	Medicine by rule informing the patient that:
153	1. If the test indicates that the patient has influenza,
154	the patient is advised to seek followup care from the patient's
155	primary care physician or, if the patient has no primary care
156	physician, from the pharmacist's supervising physician; and
157	2. If the pharmacist treats the patient for influenza, the
158	pharmacist and the pharmacy where the testing and treating
159	occurred are liable for damages the patient suffers as a result
160	of an adverse reaction to the treatment.
161	(h) The pharmacist's treatment is limited to medications
162	designed to treat influenza which are approved by the Board of
163	Medicine and which the Board of Medicine shall review annually.
164	(i) The pharmacist, prior to treating the patient, reviews
165	the patient's current prescriptions and recent prescription
166	history to check for relative contraindications involving the
167	pharmacist's intended treatment.
168	(2) A pharmacist may not enter into a written protocol
169	under this section unless he or she maintains at least \$250,000
170	of professional liability insurance and is certified as required
171	in paragraph (1)(d).
172	(3) A pharmacist who tests for and treats influenza shall
173	maintain and make available patient records using the same
174	standards for confidentiality and maintenance of such records as
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	588-03836-20 2020714c				
75	those that are imposed on health care practitioners under s.				
76	456.057. Each patient's records maintained under this subsection				
77	must include confirmation that the requirements of paragraphs				
78	(1)(e) and (1)(g) were fulfilled. Such records shall be				
79	maintained for at least 5 years.				
30	(4) The decision by a supervising physician licensed under				
81	chapter 458 or chapter 459 to enter into a written protocol				
32	under this section is a professional decision on the part of the				
3	physician and a person may not interfere with a physician's				
34	decision regarding entering into such a protocol. A pharmacist				
35	may not enter into a written protocol that is to be performed				
86	while acting as an employee without the written approval of the				
7	owner of the pharmacy.				
8	(5) The Board of Medicine, in consultation with the board				
9	and the Board of Osteopathic Medicine, shall adopt rules				
0	establishing requirements for the written protocol within 90				
1	days after the date upon which this section becomes effective.				
2	At a minimum, the written protocol shall include:				
3	(a) The terms and conditions required in s. 465.189(7).				
4	(b) Specific categories of patients for whom the				
5	supervising physician authorizes the pharmacist to test for and				
6	treat influenza.				
7	(c) The supervising physician's instructions for the				
8	treatment of influenza based on the patient's age, symptoms, and				
9	test results, including negative results.				
0	(d) A process and schedule for the supervising physician to				
1	review the pharmacist's actions under the written protocol.				
2	(e) A process and schedule for the pharmacist to notify the				
3	supervising physician of the patient's condition, tests				

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204	administered, test results, and course of treatment.
205	(6) When the patient has a primary care provider, a
206	pharmacist who provides testing for or treatment of influenza
207	under this section shall notify the patient's primary care
208	provider within 2 business days after providing any such testing
209	or treatment.
210	(7) If a pharmacist tests for and treats influenza for a
211	patient under this section, the pharmacist or his or her
212	designee must follow up with the patient 3 days later to
213	determine whether the patient's condition has improved, and if
214	the patient informs the pharmacist that his or her condition has
215	not improved, the pharmacist shall do all of the following:
216	(a) Recommend that the patient seek treatment from the
217	patient's primary care physician or, if the patient has no
218	primary care physician, from the pharmacist's supervising
219	physician.
220	(b) Inform the patient's primary care physician that the
221	patient's condition failed to improve 3 days after treatment or,
222	if the patient has no primary care physician, the pharmacist
223	shall so inform the pharmacist's supervising physician.
224	(c) Document in the patient's record maintained under
225	subsection (3) whether the followup required under this
226	subsection occurred or whether attempts to contact the patient
227	were unsuccessful.
228	(8) A pharmacist may not test for or treat influenza under
229	this section for a patient who:
230	(a) Is younger than 18 years of age;
231	(b) Is older than 75 years of age;
232	(c) Refuses to provide a medical history under paragraph
I	
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233	(1) (e); or			
234	(d) Provides a medical history under paragraph (1)(e)			
235	indicating a history of conditions relating to heart disease,			
236	bronchial disorders, pneumonia, chronic obstructive pulmonary			
237	disease, asthma, or any other medical conditions as determined			
238	by the Board of Medicine by rule on an annual basis.			
239	(9) A supervising physician who enters into a written			
240	protocol with a pharmacist under this section must be a primary			
241	care physician who is actively practicing in the community in			
242	which the pharmacist tests and treats under this section			
243	according to Board of Medicine rule. A supervising physician may			
244	not enter into such a protocol with pharmacists employed at more			
245	than four pharmacy locations.			
246	(10) Implementation of this section is contingent upon the			
247	enactment of an appropriation within the General Appropriations			
248	Act which is sufficient to fund the Board of Medicine's efforts			
249	to carry out its duties as required under this section.			
250	Section 4. This act shall take effect upon becoming a law.			
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# 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.)

Prepare	ed By: The Pro	fessional St	aff of the Approp	riations Subcommi	ttee on Health and Human Services
BILL:	SB 926				
INTRODUCER:	Senator H	arrell			
SUBJECT:	Health Ca	re Practitic	oner Licensure		
DATE:	February 2	24, 2020	REVISED:		
ANAL	YST	STAFI	- DIRECTOR	REFERENCE	ACTION
. Kibbey		Brown		HP	Favorable
2. Howard		Kidd		AHS	<b>Recommend: Favorable</b>
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

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*, <u>http://www.ncsl.org/bookstore/state-legislatures-magazine/occupational-licensing-can-balance-safety-and-employment-opportunities.aspx</u> (last visited Jan. 22, 2020).

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* <u>http://www.csg.org/knowledgecenter/docs/ncic/CompactsAgencies98.pdf</u> (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, <u>http://knowledgecenter.csg.org/kc/system/files/Bowman%202017.pdf</u>, (last visited Jan. 22, 2020).

⁴ Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. 9, *available at* <u>https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-</u>

<u>portability/license portability policy paper.pdf</u> (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.

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

⁷ Id.

⁸ Interstate Medical Licensure Compact, *The IMLC*, <u>https://imlcc.org/</u> (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

⁹ Interstate Medical Licensure Compact, Section 11, (d), p. 11, <u>https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf</u> (last visited Jan. 22, 2020).

¹⁰ Interstate Medical Licensure Compact, *The IMLC*, <u>https://imlcc.org/</u> (last visited Jan. 22, 2020).

¹¹ Interstate Medical Licensure Compact, Do I Qualify, <u>https://imlcc.org/do-i-qualify/</u> (last visited Jan. 22, 2020).

¹² Interstate Medical Licensure Compact, What Does It Cost? <u>https://imlcc.org/what-does-it-cost/</u> (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*, <u>https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted</u> (last visited Jan. 22, 2020).

¹⁶ *Id*.

¹⁷ Florida Board of Medicine, *Medical Doctor Unrestricted - Process*, <u>https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/</u> (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				
Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.				
Issue	Medical Physicians	Osteopathic Physicians		
Regulatory Board	Board of Medicine	Board of Osteopathic		
	s. 458.307, F.S.	Medicine		
		s. 459.004, F.S.		
Rulemaking Authority	s. 458.309., F.S.	s. 459.005, F.S.		
General Requirements for	s. 458.311, F.S.	s. 459.0055, F.S.		
Licensure				
Licensure Types				
Restricted License	s. 458.310, F.S.	No provision		
Restricted License	s. 458.3115, F.S.	No provision		
Certain foreign physicians				
Licensure by Endorsement	s. 458.313, F.S.	No provision		
Temporary Certificate	s. 458.3135, F.S.	No provision		
(Approved Cancer Centers)				
Temporary Certificate	s. 458.3137, F.S.	No provision		
(Training Programs)				
Medical Faculty Certificate	s. 458.3145, F.S.	s. 459.0077, F.S.		
Temporary Certificate	s. 458.315, F.S.	s. 459.0076, F.S.		
Areas of Critical Need				

²¹ See ss. 458.311, F.S. and 459.0055, F.S.

Statutory References for Practice Acts - Licensure				
Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.				
Issue	Medical Physicians	Osteopathic Physicians		
Temporary Certificate	s. 458.3151, F.S.	s. 459.00761, F.S.		
Areas of Critical Need –				
Active Duty Military &				
Veterans				
Public Health Certificate	s. 458.316, F.S.	No provision		
Public Psychiatry	s. 458.3165, F.S.	No provision		
Certificate				
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.	s. 459.008, F.S.		
	\$500/max/biennial renewal			
Financial Responsibility	s. 458.320, F.S.	s. 459.0085, F.S.		
Condition of Licensure				
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 examination²² 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 physicians³⁰. 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.

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) <u>http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/enforcement-process-chart.pdf</u>). (last visited Jan. 23, 2020).

³³ Fla. Department of Health, Consumer Services – Administrative Complaint Process, <u>http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html</u> (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

⁴¹ *Id*.

³⁴ See ss. 458.351(5) and 459.026(5), F.S.

³⁵ See ss. 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*.

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),

⁴²Office of Inspector General, *Background Information*, <u>https://oig.hhs.gov/exclusions/background.asp</u> (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 19-0745**

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* <u>http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1907rpt.pdf</u> (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				
Section	Title	Description			
1	Provides the purpose of the Compact	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).			
	Establishes prevailing standard of care	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 Establishes standard definitions for	<ul> <li>Definitions are provided for:</li> <li>Bylaws: means those Bylaws established by the Commission pursuant to Section 11 for its governance, direction, and control of its actions and conduct.</li> <li>Commissioner: means the voting representative appointed by each member board pursuant to Section 11 whereby each member state</li> </ul>			

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

	Provisions of the Interstate Medical Licensure Compact				
Section Title		Description			
Section		<ul> <li>Description</li> <li>appoints two members to the Commission. If the member state has two medical boards, the two representatives should be split between the two boards.</li> <li>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.</li> <li>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.</li> <li>Interstate Commission: means the interstate commission created pursuant to Section 11.</li> <li>License: means authorization by a state for a physician to engage in 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.)</li> <li>Member Board for osteopathic medicine, under ch. 459, F.S.)</li> <li>Member Board 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.)</li> <li>Member State: means a state that has enacted the Compact.</li> <li>Practice of medicine: means the diagnosis, treatment, prevention, cure, or relieving of a burst of the state 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.</li> </ul>			
		<ul> <li>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.)</li> <li>Member State: means a state that has enacted the Compact.</li> </ul>			
		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			
		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			

	Provisio	ns of the Interstate Medical Licensure Compact		
Section Title		Description		
Section		<ul> <li><b>Description</b></li> <li>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.</li> <li>Offense means: A felony, high court misdemeanor, or crime of moral turpitude.</li> <li>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. The term includes the amendment, repeal, or suspension of an existing rule.</li> <li>State means: Any state, commonwealth, district, or territory of the United States.</li> <li>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.</li> </ul>		
3	Eligibility 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). 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) 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: - The physician has his/her primary residence, or - The physician has at least 25 percent of his/her practice, or - The state where the physician's employer is located. 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				
Section Title		Description			
		Commission is authorized to develop rules to facilitate the re-			
		designation process.			
5	Application and	Section 5 of the Compact establishes the process for the issuance of			
	Issuance of	the expedited license.			
	Expedited				
	Licensure	A physician must file an application with the member board of the			
		state selected as the SPL. The SPL will evaluate the application to			
	Qualifications	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.			
		- Static Qualifications: Include verification of medical education,			
	Commission	graduate medical education, results of any medical or licensing			
	rulemaking	examinations and any other qualifications set by the Commission			
	provisions	through rule.			
		- 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.			
		- Appeals on eligibility determinations are handled through the member			
		state.			
		- 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.			
		- 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.			
		- 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.			
		- 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.			
		- The Commission is authorized to develop rules relating to the			
6	Fees for	application process, including fees and issuing the expedited license. A member state is authorized to charge a fee for an expedited			
U	Expedited	license that is issued or renewed through the Compact. (In Florida,			
	Licensure	the DOH is already authorized under current law to charge fees for			
	LICCHSUIC	physician licensure.)			
	Rulemaking	physician neclisare.)			
	authority	The Commission is authorized is develop rules relating to fees for			
	μπιστιτγ	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.			
		memoer states.			

	Provisions of the Interstate Medical Licensure Compact		
Section	Title	Description	
7	Renewal and Continued Participation	<ul> <li>A physician with an expedited license in a member state must complete a renewal process with the Commission if the physician:</li> <li>Maintains a full and unrestricted license in a SPL.</li> </ul>	
	Renewal license process created	<ul> <li>Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction.</li> <li>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.</li> <li>Has not had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement</li> </ul>	
	Continuing education required for renewal with	Administration. Physicians are required to comply with all continuing education and professional development requirements for renewal of a license issued by a member state.	
	renewal with member state Fees collected, if any, by	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	
	member state.	also be shared with all member boards. The Commission is authorized to develop rules to address the	
	authority.	renewal of licenses.	
8	Coordinated Information Systems <i>Authorized to</i>	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	
	create database of all	be reported to the Commission.	
	applicants	Upon request, member boards shall share complaint or disciplinary information about physicians to another member board. All	
	By request, may share data	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.	
	Rulemaking authority	The Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.	
9	Joint Investigations	Licensure and disciplinary records of physicians are deemed investigative.	
	Permits joint investigations between the	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.	
		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	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.	
	Discipline by a member state has reciprocal actions	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.	
	Licensure actions specific actions to reinstate	<ul> <li>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:</li> <li>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</li> <li>Pursue separate disciplinary action against the physician under the Medical Practice Act, regardless of the action taken in other member states.</li> <li>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.</li> </ul>	

Section 11	TitleInterstate	ns of the Interstate Medical Licensure Compact Description
11		The membrane states and the Internet Medical Lines and Comments
	Medical Licensure Compact 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.
	Recognizes creation of Commission and state's representative with 2 Commissioners,	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.
	one from each regulatory board Availability of Commission meetings,	<ul> <li>A Commissioner shall be:</li> <li>An allopathic or osteopathic physician appointed to a member board;</li> <li>Executive director, executive secretary, or similar executive of a member board; or</li> <li>Member of the public appointed to a member board.</li> <li>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</li> </ul>
	except for certain topics Availability of public data from the	<ul><li>shall call for all meeting upon the request of a majority of the member states.</li><li>Meetings are permitted via telecommunication according to the Bylaws.</li></ul>
	Commission Public notice required Creates an executive committee to	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.
	act on behalf of the Commission	<ul> <li>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: <ul> <li>Relate solely to the internal personnel practices and procedures of the Interstate Commission;</li> <li>Discuss matters specifically exempted from disclosure by federal statute;</li> <li>Discuss trade secrets, commercial, or financial information that is</li> </ul> </li> </ul>

	Provisions of the Interstate Medical Licensure Compact		
Section	Title	Description	
		<ul> <li>Involve accusing a person of a crime, or formally censuring a person;</li> <li>Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;</li> <li>Discuss investigative records compiled for law enforcement purposes; or</li> <li>Specifically relate to the participation in a civil action or other legal proceeding.</li> </ul>	
		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.	
		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.	
		The Commission may establish other committees for governance and administration of the Compact.	
12	Powers and Duties of the Interstate Commission <i>Recognizes</i> <i>creation of the</i> <i>Commission</i>	<ul> <li>The Commission shall have the duties and the powers to: <ul> <li>Oversee and administer the Compact;</li> <li>Promulgate rules, which are binding;</li> <li>Issue advisory opinions upon the request of member states concerning the meaning or interpretation of the Compact or its bylaws, rules, and actions;</li> <li>Enforce compliance with the Compact, provisions, the rules, and the bylaws;</li> <li>Establish and appoint committees, including the executive committee, which has the power to act on behalf of the Interstate Commission;</li> <li>Pay, or provide for the payment of Commission expenses;</li> <li>Establish and maintain one or more offices;</li> <li>Borrow, accept, hire, or contract for services of personnel;</li> <li>Purchase and maintain insurance and bonds;</li> <li>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;</li> <li>Establish personnel policies and programs;</li> <li>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;</li> <li>Lease, purchase, accept contributions, or donation of, or otherwise own, hold, improve or use, any property, real, personal, or mixed;</li> <li>Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;</li> </ul> </li> </ul>	

	Provisions of the Interstate Medical Licensure Compact		
Section	Title	Description	
		<ul> <li>Adopt a seal and bylaws governing the management and operation of the Commission;</li> <li>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;</li> <li>Coordinate education, training, and public awareness regarding the Compact, its implementation and operation;</li> <li>Maintain records in accordance with the bylaws;</li> <li>Seek and obtain trademarks, copyrights, and patents; and</li> <li>Perform such functions as may be necessary or appropriate to achieve the purpose of the Compact.</li> </ul>	
13	Finance Powers Provides for annual assessment Requires rule for any assessment No pledging credit without authorization Yearly audits	<ul> <li>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.</li> <li>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.</li> <li>The Commission must not incur obligations of any kind prior to securing the funds adequate to meet the assessment.</li> <li>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.</li> <li>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.</li> </ul>	
14	Organization and Operation of the Interstate Commission Annual officer election	<ul> <li>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</li> <li>A Chair, Vice Chair, and Treasurer shall be elected or appointed each year by the Commission.</li> <li>Officers serve without remuneration. Officers and employees are immune from suit and liability, either personally or in their</li> </ul>	

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

	Provisions of the Interstate Medical Licensure Compact		
Section	Title	Description	
	No officer remuneration	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	
	Liability protection for actions within scope of duties	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.	
	and responsibilities only for officers, employees, and agents	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.	
		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.	
		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	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	
	Promulgate reasonable	Procedures Act" of 2010 and subsequent amendments thereto.	
	rules	The Compact allows for judicial review of any promulgated rule. A petition may be filed thirty (30) days after a rule has been	
	Judicial review at U.S. Federal District Court	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, <u>https://imlcc.org/facts-about-the-imlcc/</u> (last visited Jan. 22, 2020).

	Provisions of the Interstate Medical Licensure Compact					
Section	Title	Description				
16	Oversight of Interstate Compact <i>Enforcement</i>	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.				
	Service of process	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	<ul> <li>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.</li> <li>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.</li> <li>The Compact provides an appeal process for the terminating state and procedures for attorney's fees and costs.</li> </ul>				
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, <u>https://imlcc.org/faqs/</u> (last visited Jan. 22, 2020).

	<b>Provisions of the Interstate Medical Licensure Compact</b>						
Section	Title	Description					
		action and written notice has been given by the withdrawing state to the governor of each other member state.					
		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.					
		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.					
		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.					
		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.					
		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.					
		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.					
		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)*, <u>https://imlcc.org/wp-content/uploads/2018/02/IMLCC-Rule-Chapter-1-Rule-on-Rulemaking-Adopted-June-24-2016.pdf</u> (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, <u>https://imlcc.org/facts-about-the-imlcc/</u> (last visited Jan. 22, 2020).

⁵⁵ Interstate Medical License Compact Bylaws, Section 11 – Interstate Medical License Compact Commission, Section (h)-(l), <u>https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf</u> (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 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.

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

⁶⁹ Id.

⁶⁷ Id.

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



## 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

# THE FLORIDA SENATE **APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Separat or Separate Professional Staff conducting the meeting)

02/25/20		er BOTH copies of this form to th	e Serialor of Seriale F	TOIESSIONAI SI	an conducting	the meeting)	SB 0926
Meeti	ng Date						Bill Number (if applicable)
Topic	Health Ca	re Practitioner Licensu	re.			Amend	lment Barcode (if applicable)
Name	lvonn	e Fernandez					
Job Title	Associa	ate State Director					
Address	215 Sou	th Monroe Street			Phone _	954	-850-7262
,	Tallahassee	FL			Email	ifernanc	lez@aarp.org
Speaking:	City	State		^{lip} Waive Sp (The Chai		In Su	ation into the record.)
Repre	esenting		AARP				
Appearing	g at request of Cł	nair: Yes No	Lobby	ist registe	ered with	Legislat	ure: 🖌 Yes 🗌 No
		encourage public testimo nay be asked to limit the		•	•		•

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

16

S-001 (10/14/14)

By Senator Harrell

25-01035C-20

2020926

1 A bill to be entitled 2 An act relating to health care practitioner licensure; creating s. 458.3129, F.S.; establishing that a 3 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 8 ç licensed under chapter 459; amending s. 456.0635, 10 F.S.; removing the requirement that each board within 11 the jurisdiction of the Department of Health, or the 12 department if there is no board, prohibit a candidate 13 from being examined for or issued, or having renewed a 14 license, certificate, or registration to practice a 15 health care profession if he or she is listed on a 16 specified federal list of excluded individuals and 17 entities; amending s. 456.072, F.S.; deleting a 18 provision classifying the failure to repay a student 19 loan issued or guaranteed by the state or federal 20 government in accordance with the terms of the loan as 21 a failure to perform a statutory or legal obligation; 22 removing penalties; repealing s. 456.0721, F.S., 23 relating to investigations of health care 24 practitioners in default on student loan or 25 scholarship obligations; amending s. 456.074, F.S.; 26 deleting the requirement, and related provisions, that 27 the department immediately suspend the licenses of 28 certain health care practitioners for failing to 29 provide proof of new payment terms for defaulted Page 1 of 37

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

1	25-01035C-20 2020926_
30	student loans within a specified timeframe; creating
31	s. 456.4501, F.S.; implementing the Interstate Medical
32	Licensure Compact in this state; providing for an
33	interstate medical licensure process; providing
34	requirements for multistate practice; creating s.
35	456.4502, F.S.; establishing that a formal hearing
36	before the Division of Administrative Hearings must be
37	held if there are any disputed issues of material fact
38	when the licenses of certain physicians and
39	osteopathic physicians are suspended or revoked by
40	this state under the compact; requiring the department
41	to notify the division of a petition for a formal
42	hearing within a specified timeframe; requiring the
43	administrative law judge to issue a recommended order;
44	requiring the Board of Medicine or the Board of
45	Osteopathic Medicine, as applicable, to determine and
46	issue final orders in certain cases; providing the
47	department with standing to seek judicial review of
48	any final order of the boards; creating s. 456.4504,
49	F.S.; authorizing the department to adopt rules;
50	amending s. 768.28, F.S.; designating the state
51	commissioners of the Interstate Medical Licensure
52	Compact Commission and other members or employees of
53	the commission as state agents for the purpose of
54	applying sovereign immunity and waivers of sovereign
55	immunity; requiring the commission to pay certain
56	claims or judgments; authorizing the commission to
57	maintain insurance coverage to pay such claims or
58	judgments; providing an effective date.
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	Page 2 of 37

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SB 926

	25-01035C-20 2020926		25-01035C-20 2020926
59		88	proof that the plea has been withdrawn or the charges have been
60	Be It Enacted by the Legislature of the State of Florida:	89	dismissed. Any such conviction or plea shall exclude the
61		90	applicant or candidate from licensure, examination,
62	Section 1. Section 458.3129, Florida Statutes, is created	91	certification, or registration unless the sentence and any
63	to read:	92	subsequent period of probation for such conviction or plea
64	458.3129 Interstate Medical Licensure CompactA physician	93	ended:
65	licensed to practice medicine under s. 456.4501 is deemed to	94	1. For felonies of the first or second degree, more than 15
66	also be licensed under this chapter.	95	years before the date of application.
67	Section 2. Section 459.074, Florida Statutes, is created to	96	2. For felonies of the third degree, more than 10 years
68	read:	97	before the date of application, except for felonies of the third
69	459.074 Interstate Medical Licensure CompactA physician	98	degree under s. 893.13(6)(a).
70	licensed to practice osteopathic medicine under s. 456.4501 is	99	3. For felonies of the third degree under s. $893.13(6)(a)$ ,
71	deemed to also be licensed under this chapter.	100	more than 5 years before the date of application;
72	Section 3. Subsection (2) and paragraph (e) of subsection	101	(b) Has been convicted of, or entered a plea of guilty or
73	(3) of section 456.0635, Florida Statutes, are amended to read:	102	nolo contendere to, regardless of adjudication, a felony under
74	456.0635 Health care fraud; disqualification for license,	103	21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the
75	certificate, or registration	104	sentence and any subsequent period of probation for such
76	(2) Each board within the jurisdiction of the department,	105	conviction or plea ended more than 15 years before the date of
77	or the department if there is no board, shall refuse to admit a	106	the application;
78	candidate to any examination and refuse to issue a license,	107	(c) Has been terminated for cause from the Florida Medicaid
79	certificate, or registration to any applicant if the candidate	108	program pursuant to s. 409.913, unless the candidate or
80	or applicant or any principal, officer, agent, managing	109	applicant has been in good standing with the Florida Medicaid
81	employee, or affiliated person of the candidate or applicant:	110	program for the most recent 5 years; <u>or</u>
82	(a) Has been convicted of, or entered a plea of guilty or	111	(d) Has been terminated for cause, pursuant to the appeals
83	nolo contendere to, regardless of adjudication, a felony under	112	procedures established by the state, from any other state
84	chapter 409, chapter 817, or chapter 893, or a similar felony	113	Medicaid program, unless the candidate or applicant has been in
85	offense committed in another state or jurisdiction, unless the	114	good standing with a state Medicaid program for the most recent
86	candidate or applicant has successfully completed a pretrial	115	5 years and the termination occurred at least 20 years before
87	diversion or drug court program for that felony and provides	116	the date of the application <del>; or</del>
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(c) Is currently listed on the United Stat	es Department of	146	Federal Government in accordance wit	the terms of the loan or
Health and Human Services Office of Inspector G	eneral's List of	147	failing to comply with service schol	Larship obligations shall be
Excluded Individuals and Entities.		148	considered a failure to perform a st	catutory or legal obligation,
		149	and the minimum disciplinary action	-imposed shall be a
This subsection does not apply to an applicant	for initial	150	suspension of the license until new	payment terms are agreed
licensure, certification, or registration who w	as arrested or	151	upon or the scholarship obligation	is resumed, followed by
charged with a felony specified in paragraph (a	) or paragraph	152	probation for the duration of the st	<del>udent loan or remaining</del>
(b) before July 1, 2009.		153	scholarship obligation period, and a	a fine equal to 10 percent of
(3) The department shall refuse to renew a	license,	154	the defaulted loan amount. Fines col	llected shall be deposited
certificate, or registration of any applicant i	f the applicant	155	into the Medical Quality Assurance 7	frust Fund.
or any principal, officer, agent, managing empl	oyee, or	156	Section 5. <u>Section 456.0721, Fl</u>	lorida Statutes, is repealed.
affiliated person of the applicant:		157	Section 6. Subsection (4) of se	ection 456.074, Florida
(e) Is currently listed on the United Stat	es Department of	158	Statutes, is amended to read:	
Health and Human Services Office of Inspector G	eneral's List of	159	456.074 Certain health care pra	actitioners; immediate
Excluded Individuals and Entities.		160	suspension of license	
		161	(4) Upon receipt of information	<del>i that a Florida-licensed</del>
This subsection does not apply to an applicant	for renewal of	162	health care practitioner has default	ed on a student loan issued
licensure, certification, or registration who w	as arrested or	163	or guaranteed by the state or the Fo	ederal Government, the
charged with a felony specified in paragraph (a	) or paragraph	164	department shall notify the licensee	> by certified mail that he
(b) before July 1, 2009.		165	or she shall be subject to immediate	> suspension of license
Section 4. Paragraph (k) of subsection (1)	of section	166	unless, within 45 days after the dat	e of mailing, the licensee
456.072, Florida Statutes, is amended to read:		167	provides proof that new payment term	ns have been agreed upon by
456.072 Grounds for discipline; penalties;	enforcement	168	all parties to the loan. The departm	ment shall issue an emergency
(1) The following acts shall constitute gr	ounds for which	169	order suspending the license of any	licensee who, after 45 days
the disciplinary actions specified in subsectio	n (2) may be	170	following the date of mailing from t	the department, has failed to
taken:		171	provide such proof. Production of su	ch proof shall not prohibit
(k) Failing to perform any statutory or le	gal obligation	172	the department from proceeding with	disciplinary action against
placed upon a licensee. For purposes of this se	<del>ction, failing to</del>	173	the licensee pursuant to s. 456.073.	<del>.</del>
repay a student loan issued or guaranteed by th	e state or the	174	Section 7. Section 456.4501, FI	lorida Statutes, is created
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175	to read:
176	456.4501 Interstate Medical Licensure CompactThe
177	Interstate Medical Licensure Compact is hereby enacted into law
178	and entered into by this state with all other jurisdictions
179	legally joining therein in the form substantially as follows:
180	
181	SECTION 1
182	PURPOSE
183	
184	In order to strengthen access to health care, and in
185	recognition of the advances in the delivery of health care, the
186	member states of the Interstate Medical Licensure Compact have
L87	allied in common purpose to develop a comprehensive process that
L 8 8	complements the existing licensing and regulatory authority of
89	state medical boards, provides a streamlined process that allows
90	physicians to become licensed in multiple states, thereby
91	enhancing the portability of a medical license and ensuring the
92	safety of patients. The Compact creates another pathway for
93	licensure and does not otherwise change a state's existing
94	Medical Practice Act. The Compact also adopts the prevailing
95	standard for licensure and affirms that the practice of medicine
96	occurs where the patient is located at the time of the
97	physician-patient encounter, and therefore, requires the
98	physician to be under the jurisdiction of the state medical
99	board where the patient is located. State medical boards that
00	participate in the Compact retain the jurisdiction to impose an
201	adverse action against a license to practice medicine in that
202	state issued to a physician through the procedures in the
203	Compact.
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i.	
204	
205	SECTION 2
206	DEFINITIONS
207	
208	In this compact:
209	(a) "Bylaws" means those bylaws established by the
210	Interstate Commission pursuant to Section 11 for its governance,
211	or for directing and controlling its actions and conduct.
212	(b) "Commissioner" means the voting representative
213	appointed by each member board pursuant to Section 11.
214	(c) "Conviction" means a finding by a court that an
215	individual is guilty of a criminal offense through adjudication,
216	or entry of a plea of guilt or no contest to the charge by the
217	offender. Evidence of an entry of a conviction of a criminal
218	offense by the court shall be considered final for purposes of
219	disciplinary action by a member board.
220	(d) "Expedited License" means a full and unrestricted
221	medical license granted by a member state to an eligible
222	physician through the process set forth in the Compact.
223	(e) "Interstate Commission" means the interstate commission
224	created pursuant to Section 11.
225	(f) "License" means authorization by a state for a
226	physician to engage in the practice of medicine, which would be
227	unlawful without the authorization.
228	(g) "Medical Practice Act" means laws and regulations
229	governing the practice of allopathic and osteopathic medicine
230	within a member state.
231	(h) "Member Board" means a state agency in a member state
232	that acts in the sovereign interests of the state by protecting
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33	the public through licensure, regulation, and education of
4	physicians as directed by the state government.
5	(i) "Member State" means a state that has enacted the
6	Compact.
7	(j) "Practice of medicine" means the diagnosis, treatment,
8	prevention, cure, or relieving of a human disease, ailment,
9	defect, complaint, or other physical or mental condition, by
0	attendance, advice, device, diagnostic test, or other means, or
1	offering, undertaking, attempting to do, or holding oneself out
2	as able to do, any of these acts.
3	(k) "Physician" means any person who:
4	(1) Is a graduate of a medical school accredited by the
5	Liaison Committee on Medical Education, the Commission on
6	Osteopathic College Accreditation, or a medical school listed in
7	the International Medical Education Directory or its equivalent;
В	(2) Passed each component of the United States Medical
9	Licensing Examination (USMLE) or the Comprehensive Osteopathic
0	Medical Licensing Examination (COMLEX-USA) within three
1	attempts, or any of its predecessor examinations accepted by a
2	state medical board as an equivalent examination for licensure
3	purposes;
1	(3) Successfully completed graduate medical education
5	approved by the Accreditation Council for Graduate Medical
6	Education or the American Osteopathic Association;
7	(4) Holds specialty certification or a time-unlimited
8	specialty certificate recognized by the American Board of
9	Medical Specialties or the American Osteopathic Association's
0	Bureau of Osteopathic Specialists; however, the specialty
1	certification or a time-unlimited specialty certificate does not

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i.	25-01035C-20 2020926
262	have to be maintained once a physician is initially determined
263	to be eligible for expedited licensure through the Compact;
264	(5) Possesses a full and unrestricted license to engage in
265	the practice of medicine issued by a member board;
266	(6) Has never been convicted, received adjudication,
267	deferred adjudication, community supervision, or deferred
268	disposition for any offense by a court of appropriate
269	jurisdiction;
270	(7) Has never held a license authorizing the practice of
271	medicine subjected to discipline by a licensing agency in any
272	state, federal, or foreign jurisdiction, excluding any action
273	related to non-payment of fees related to a license;
274	(8) Has never had a controlled substance license or permit
275	suspended or revoked by a state or the United States Drug
276	Enforcement Administration; and
277	(9) Is not under active investigation by a licensing agency
278	or law enforcement authority in any state, federal, or foreign
279	jurisdiction.
280	(1) "Offense" means a felony, high court misdemeanor, or
281	crime of moral turpitude.
282	(m) "Rule" means a written statement by the Interstate
283	Commission promulgated pursuant to Section 12 of the Compact
284	that is of general applicability, implements, interprets, or
285	prescribes a policy or provision of the Compact, or an
286	organizational, procedural, or practice requirement of the
287	Interstate Commission, and has the force and effect of statutory
288	law in a member state, if the rule is not inconsistent with the
289	laws of the member state. The term includes the amendment,
290	repeal, or suspension of an existing rule.
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291	(n) "State" means any state, commonwealth, district, or
292	territory of the United States.
293	(o) "State of Principal License" means a member state where
294	a physician holds a license to practice medicine and which has
295	been designated as such by the physician for purposes of
296	registration and participation in the Compact.
297	
298	SECTION 3
299	ELIGIBILITY
300	
301	(a) A physician must meet the eligibility requirements as
302	defined in Section 2(k) to receive an expedited license under
303	the terms and provisions of the Compact.
304	(b) A physician who does not meet the requirements of
305	Section 2(k) may obtain a license to practice medicine in a
306	member state if the individual complies with all laws and
307	requirements, other than the Compact, relating to the issuance
308	of a license to practice medicine in that state.
309	
310	SECTION 4
311	DESIGNATION OF STATE OF PRINCIPAL LICENSE
312	
313	(a) A physician shall designate a member state as the state
314	of principal license for purposes of registration for expedited
315	licensure through the Compact if the physician possesses a full
316	and unrestricted license to practice medicine in that state, and
317	the state is:
318	(1) The state of primary residence for the physician, or
319	(2) The state where at least 25% of the practice of
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320	medicine occurs, or
321	(3) The location of the physician's employer, or
322	(4) If no state qualifies under subsection (1), subsection
323	(2), or subsection (3), the state designated as state of
324	residence for purpose of federal income tax.
325	(b) A physician may redesignate a member state as state of
326	principal license at any time, as long as the state meets the
327	requirements in subsection (a).
327	(c) The Interstate Commission is authorized to develop
329	rules to facilitate redesignation of another member state as the
330	ž
	state of principal license.
331	
332	SECTION 5
333	APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE
334	
335	(a) A physician seeking licensure through the Compact shall
336	file an application for an expedited license with the member
337	board of the state selected by the physician as the state of
338	principal license.
339	(b) Upon receipt of an application for an expedited
340	license, the member board within the state selected as the state $\$
341	of principal license shall evaluate whether the physician is
342	eligible for expedited licensure and issue a letter of
343	qualification, verifying or denying the physician's eligibility,
344	to the Interstate Commission.
345	(1) Static qualifications, which include verification of
346	medical education, graduate medical education, results of any
347	medical or licensing examination, and other qualifications as
348	determined by the Interstate Commission through rule, shall not
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349	be subject to additional primary source verification where
350	already primary source verified by the state of principal
351	license.
352	(2) The member board within the state selected as the state
353	of principal license shall, in the course of verifying
354	eligibility, perform a criminal background check of an
355	applicant, including the use of the results of fingerprint or
356	other biometric data checks compliant with the requirements of
357	the Federal Bureau of Investigation, with the exception of
358	federal employees who have suitability determination in
359	accordance with U.S. 5 C.F.R. s. 731.202.
360	(3) Appeal on the determination of eligibility shall be
361	made to the member state where the application was filed and
362	shall be subject to the law of that state.
363	(c) Upon verification in subsection (b), physicians
364	eligible for an expedited license shall complete the
365	registration process established by the Interstate Commission to
366	receive a license in a member state selected pursuant to
367	subsection (a), including the payment of any applicable fees.
368	(d) After receiving verification of eligibility under
369	subsection (b) and any fees under subsection (c), a member board
370	shall issue an expedited license to the physician. This license
371	shall authorize the physician to practice medicine in the
372	issuing state consistent with the Medical Practice Act and all
373	applicable laws and regulations of the issuing member board and
374	member state.
375	(e) An expedited license shall be valid for a period
376	consistent with the licensure period in the member state and in
377	the same manner as required for other physicians holding a full
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378	and unrestricted license within the member state.
379	(f) An expedited license obtained through the Compact shall
380	be terminated if a physician fails to maintain a license in the
381	state of principal licensure for a non-disciplinary reason,
382	without redesignation of a new state of principal licensure.
383	(g) The Interstate Commission is authorized to develop
384	rules regarding the application process, including payment of
385	any applicable fees, and the issuance of an expedited license.
386	
387	SECTION 6
388	FEES FOR EXPEDITED LICENSURE
389	
390	(a) A member state issuing an expedited license authorizing
391	the practice of medicine in that state, or the regulating
392	authority of the member state, may impose a fee for a license
393	issued or renewed through the Compact.
394	(b) The Interstate Commission is authorized to develop
395	rules regarding fees for expedited licenses. However, those
396	rules shall not limit the authority of a member state, or the
397	regulating authority of the member state, to impose and
398	determine the amount of a fee under subsection (a).
399	
400	SECTION 7
401	RENEWAL AND CONTINUED PARTICIPATION
402	
403	(a) A physician seeking to renew an expedited license
404	granted in a member state shall complete a renewal process with
405	the Interstate Commission if the physician:
406	(1) Maintains a full and unrestricted license in a state of
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407	principal license;		436	
408	(2) Has not been convicted, received adjudication, de	eferred	437	(a) The Interstate Commission shall establish a database
09	adjudication, community supervision, or deferred disposit:	ion for	438	all physicians licensed, or who have applied for licensure,
10	any offense by a court of appropriate jurisdiction;		439	under Section 5.
11	(3) Has not had a license authorizing the practice of	<u>f</u>	440	(b) Notwithstanding any other provision of law, member
12	medicine subject to discipline by a licensing agency in an	ny	441	boards shall report to the Interstate Commission any public
13	state, federal, or foreign jurisdiction, excluding any act	tion	442	action or complaints against a licensed physician who has
14	related to non-payment of fees related to a license; and		443	applied or received an expedited license through the Compact.
15	(4) Has not had a controlled substance license or per	rmit	444	(c) Member boards shall report disciplinary or
16	suspended or revoked by a state or the United States Drug		445	investigatory information determined as necessary and proper
17	Enforcement Administration.		446	rule of the Interstate Commission.
18	(b) Physicians shall comply with all continuing		447	(d) Member boards may report any non-public complaint,
19	professional development or continuing medical education		448	disciplinary, or investigatory information not required by
20	requirements for renewal of a license issued by a member a	state.	449	subsection (c) to the Interstate Commission.
21	(c) The Interstate Commission shall collect any renew	wal ·	450	(e) Member boards shall share complaint or disciplinary
22	fees charged for the renewal of a license and distribute t	the	451	information about a physician upon request of another member
23	fees to the applicable member board.		452	board.
24	(d) Upon receipt of any renewal fees collected in		453	(f) All information provided to the Interstate Commission
25	subsection (c), a member board shall renew the physician's	<u>s</u>	454	or distributed by member boards shall be confidential, filed
26	license.		455	under seal, and used only for investigatory or disciplinary
27	(e) Physician information collected by the Interstate	<u>e</u>	456	matters.
28	$\underline{ \mbox{Commission during the renewal process will be distributed} }$	to all	457	(g) The Interstate Commission is authorized to develop
29	member boards.		458	rules for mandated or discretionary sharing of information by
30	(f) The Interstate Commission is authorized to develo	<u>op</u>	459	member boards.
31	$\underline{ \mbox{rules}}$ to address renewal of licenses obtained through the		460	
32	Compact.		461	SECTION 9
33			462	JOINT INVESTIGATIONS
34	SECTION 8		463	
35	COORDINATED INFORMATION SYSTEM		464	(a) Licensure and disciplinary records of physicians are
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465	deemed investigative.	
466	(b) In addition to the authority granted to a member board	
467	by its respective Medical Practice Act or other applicable state	
468	law, a member board may participate with other member boards in	
469	joint investigations of physicians licensed by the member	
470	boards.	
471	(c) A subpoena issued by a member state shall be	
472	enforceable in other member states.	
473	(d) Member boards may share any investigative, litigation,	
474	or compliance materials in furtherance of any joint or	
475	individual investigation initiated under the Compact.	
476	(e) Any member state may investigate actual or alleged	
477	violations of the statutes authorizing the practice of medicine	
478	in any other member state in which a physician holds a license	
479	to practice medicine.	
480		
481	SECTION 10	
482	DISCIPLINARY ACTIONS	
483		
484	(a) Any disciplinary action taken by any member board	
485	against a physician licensed through the Compact shall be deemed	
486	unprofessional conduct which may be subject to discipline by	
487	other member boards, in addition to any violation of the Medical	
488	Practice Act or regulations in that state.	
489	(b) If a license granted to a physician by the member board	
490	in the state of principal license is revoked, surrendered or	
491	relinquished in lieu of discipline, or suspended, then all	
492	licenses issued to the physician by member boards shall	
493	automatically be placed, without further action necessary by any	
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494	member board, on the same status. If the member board in the
495	state of principal license subsequently reinstates the
496	physician's license, a license issued to the physician by any
497	other member board shall remain encumbered until that respective
498	member board takes action to reinstate the license in a manner
499	consistent with the Medical Practice Act of that state.
500	(c) If disciplinary action is taken against a physician by
501	a member board not in the state of principal license, any other
502	member board may deem the action conclusive as to matter of law
503	and fact decided, and:
504	(1) Impose the same or lesser sanction(s) against the
505	physician so long as such sanctions are consistent with the
506	Medical Practice Act of that state; or
507	(2) Pursue separate disciplinary action against the
508	physician under its respective Medical Practice Act, regardless
509	of the action taken in other member states.
510	(d) If a license granted to a physician by a member board
511	is revoked, surrendered or relinquished in lieu of discipline,
512	or suspended, then any license(s) issued to the physician by any
513	other member board(s) shall be suspended, automatically and
514	immediately without further action necessary by the other member
515	board(s), for ninety (90) days upon entry of the order by the
516	disciplining board, to permit the member board(s) to investigate
517	the basis for the action under the Medical Practice Act of that
518	state. A member board may terminate the automatic suspension of
519	the license it issued prior to the completion of the ninety (90
520	day suspension period in a manner consistent with the Medical
521	Practice Act of that state.
522	
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523	SECTION 11
524	INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION
525	
526	(a) The member states hereby create the "Interstate Medical
527	Licensure Compact Commission."
528	(b) The purpose of the Interstate Commission is the
529	administration of the Interstate Medical Licensure Compact,
530	which is a discretionary state function.
531	(c) The Interstate Commission shall be a body corporate and
532	joint agency of the member states and shall have all the
533	responsibilities, powers, and duties set forth in the Compact,
534	and such additional powers as may be conferred upon it by a
535	subsequent concurrent action of the respective legislatures of
536	the member states in accordance with the terms of the Compact.
537	(d) The Interstate Commission shall consist of two voting
538	representatives appointed by each member state who shall serve
539	as Commissioners. In states where allopathic and osteopathic
540	physicians are regulated by separate member boards, or if the
541	licensing and disciplinary authority is split between multiple
542	member boards within a member state, the member state shall
543	appoint one representative from each member board. A
544	Commissioner shall be a(n):
545	(1) Allopathic or osteopathic physician appointed to a
546	member board;
547	(2) Executive director, executive secretary, or similar
548	executive of a member board; or
549	(3) Member of the public appointed to a member board.
550	(e) The Interstate Commission shall meet at least once each
551	calendar year. A portion of this meeting shall be a business
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552	meeting to address such matters as may properly come before the
553	Commission, including the election of officers. The chairperson
554	may call additional meetings and shall call for a meeting upon
555	the request of a majority of the member states.
556	(f) The bylaws may provide for meetings of the Interstate
557	Commission to be conducted by telecommunication or electronic
558	communication.
559	(g) Each Commissioner participating at a meeting of the
560	Interstate Commission is entitled to one vote. A majority of
561	Commissioners shall constitute a quorum for the transaction of
562	business, unless a larger quorum is required by the bylaws of
563	the Interstate Commission. A Commissioner shall not delegate a
564	vote to another Commissioner. In the absence of its
565	Commissioner, a member state may delegate voting authority for a
566	specified meeting to another person from that state who shall
567	meet the requirements of subsection (d).
568	(h) The Interstate Commission shall provide public notice
569	of all meetings and all meetings shall be open to the public.
570	The Interstate Commission may close a meeting, in full or in
571	portion, where it determines by a two-thirds vote of the
572	Commissioners present that an open meeting would be likely to:
573	(1) Relate solely to the internal personnel practices and
574	procedures of the Interstate Commission;
575	(2) Discuss matters specifically exempted from disclosure
576	by federal statute;
577	(3) Discuss trade secrets, commercial, or financial
578	information that is privileged or confidential;
579	(4) Involve accusing a person of a crime, or formally
580	censuring a person;
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581	(5) Discuss information of a personal nature where
582	disclosure would constitute a clearly unwarranted invasion of
583	personal privacy;
584	(6) Discuss investigative records compiled for law
585	enforcement purposes; or
586	(7) Specifically relate to the participation in a civil
587	action or other legal proceeding.
588	(i) The Interstate Commission shall keep minutes which
589	shall fully describe all matters discussed in a meeting and
590	shall provide a full and accurate summary of actions taken,
591	including record of any roll call votes.
592	(j) The Interstate Commission shall make its information
593	and official records, to the extent not otherwise designated in
594	the Compact or by its rules, available to the public for
595	inspection.
596	(k) The Interstate Commission shall establish an executive
597	committee, which shall include officers, members, and others as
598	determined by the bylaws. The executive committee shall have the
599	power to act on behalf of the Interstate Commission, with the
600	exception of rulemaking, during periods when the Interstate
601	Commission is not in session. When acting on behalf of the
602	Interstate Commission, the executive committee shall oversee the
603	administration of the Compact including enforcement and
604	compliance with the provisions of the Compact, its bylaws and
605	rules, and other such duties as necessary.
606	(1) The Interstate Commission may establish other
607	committees for governance and administration of the Compact.
608	
609	SECTION 12
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610	POWERS AND DUTIES OF THE INTERSTATE COMMISSION
611	
612	The Interstate Commission shall have the duty and power to:
613	(a) Oversee and maintain the administration of the Compact;
614	(b) Promulgate rules which shall be binding to the extent
615	and in the manner provided for in the Compact;
616	(c) Issue, upon the request of a member state or member
617	board, advisory opinions concerning the meaning or
618	interpretation of the Compact, its bylaws, rules, and actions;
619	(d) Enforce compliance with Compact provisions, the rules
620	promulgated by the Interstate Commission, and the bylaws, using
621	all necessary and proper means, including but not limited to the
622	use of judicial process;
623	(e) Establish and appoint committees including, but not
624	limited to, an executive committee as required by Section 11,
625	which shall have the power to act on behalf of the Interstate
626	Commission in carrying out its powers and duties;
627	(f) Pay, or provide for the payment of the expenses related
628	to the establishment, organization, and ongoing activities of
629	the Interstate Commission;
630	(g) Establish and maintain one or more offices;
631	(h) Borrow, accept, hire, or contract for services of
632	personnel;
633	(i) Purchase and maintain insurance and bonds;
634	(j) Employ an executive director who shall have such powers
635	to employ, select or appoint employees, agents, or consultants,
636	and to determine their qualifications, define their duties, and
637	fix their compensation;
638	(k) Establish personnel policies and programs relating to
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639	conflicts of interest, rates of compensation, and qualifications
640	of personnel;
641	(1) Accept donations and grants of money, equipment,
642	supplies, materials and services, and to receive, utilize, and
643	dispose of it in a manner consistent with the conflict of
644	interest policies established by the Interstate Commission;
645	(m) Lease, purchase, accept contributions or donations of,
646	or otherwise to own, hold, improve or use, any property, real,
647	personal, or mixed;
648	(n) Sell, convey, mortgage, pledge, lease, exchange,
649	abandon, or otherwise dispose of any property, real, personal,
650	or mixed;
651	(o) Establish a budget and make expenditures;
652	(p) Adopt a seal and bylaws governing the management and
653	operation of the Interstate Commission;
654	(q) Report annually to the legislatures and governors of
655	the member states concerning the activities of the Interstate
656	Commission during the preceding year. Such reports shall also
657	include reports of financial audits and any recommendations that
658	may have been adopted by the Interstate Commission;
659	(r) Coordinate education, training, and public awareness
660	regarding the Compact, its implementation, and its operation;
661	(s) Maintain records in accordance with the bylaws;
662	(t) Seek and obtain trademarks, copyrights, and patents;
663	and
664	(u) Perform such functions as may be necessary or
665	appropriate to achieve the purposes of the Compact.
666	
667	SECTION 13
1	Page 23 of 37
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668	FINANCE POWERS
669	
670	(a) The Interstate Commission may levy on and collect an
671	annual assessment from each member state to cover the cost of
672	the operations and activities of the Interstate Commission and
673	its staff. The total assessment, subject to appropriation, must
674	be sufficient to cover the annual budget approved each year for
675	which revenue is not provided by other sources. The aggregate
676	annual assessment amount shall be allocated upon a formula to be
677	determined by the Interstate Commission, which shall promulgate
678	a rule binding upon all member states.
679	(b) The Interstate Commission shall not incur obligations
680	of any kind prior to securing the funds adequate to meet the
681	same.
682	(c) The Interstate Commission shall not pledge the credit
683	of any of the member states, except by, and with the authority
684	of, the member state.
685	(d) The Interstate Commission shall be subject to a yearly
686	financial audit conducted by a certified or licensed public
687	accountant and the report of the audit shall be included in the
688	annual report of the Interstate Commission.
689	
690	SECTION 14
691	ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION
692	
693	(a) The Interstate Commission shall, by a majority of
694	Commissioners present and voting, adopt bylaws to govern its
695	conduct as may be necessary or appropriate to carry out the
696	purposes of the Compact within twelve (12) months of the first
1	Dama 24 of 27
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697	Interstate Commission meeting.
698	(b) The Interstate Commission shall elect or appoint
699	annually from among its Commissioners a chairperson, a vice-
700	chairperson, and a treasurer, each of whom shall have such
701	authority and duties as may be specified in the bylaws. The
702	chairperson, or in the chairperson's absence or disability, the
703	vice-chairperson, shall preside at all meetings of the
704	Interstate Commission.
705	(c) Officers selected in subsection (b) shall serve without
706	remuneration from the Interstate Commission.
707	(d) The officers and employees of the Interstate Commission
708	shall be immune from suit and liability, either personally or in
709	their official capacity, for a claim for damage to or loss of
710	property or personal injury or other civil liability caused or
711	arising out of, or relating to, an actual or alleged act, error,
712	or omission that occurred, or that such person had a reasonable
713	basis for believing occurred, within the scope of Interstate
714	Commission employment, duties, or responsibilities; provided
715	that such person shall not be protected from suit or liability
716	for damage, loss, injury, or liability caused by the intentional
717	or willful and wanton misconduct of such person.
718	(1) The liability of the executive director and employees
719	of the Interstate Commission or representatives of the
720	Interstate Commission, acting within the scope of such person's
721	employment or duties for acts, errors, or omissions occurring
722	within such person's state, may not exceed the limits of
723	liability set forth under the constitution and laws of that
724	state for state officials, employees, and agents. The Interstate
725	Commission is considered to be an instrumentality of the states
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726	for the purposes of any such action. Nothing in this subsection	
727	shall be construed to protect such person from suit or liability	
728	for damage, loss, injury, or liability caused by the intentional	
729	or willful and wanton misconduct of such person.	
730	(2) The Interstate Commission shall defend the executive	
731	director, its employees, and subject to the approval of the	
732	attorney general or other appropriate legal counsel of the	
733	member state represented by an Interstate Commission	
734	representative, shall defend such Interstate Commission	
735	representative in any civil action seeking to impose liability	
736	arising out of an actual or alleged act, error or omission that	
737	occurred within the scope of Interstate Commission employment,	
738	duties or responsibilities, or that the defendant had a	
739	reasonable basis for believing occurred within the scope of	
740	Interstate Commission employment, duties, or responsibilities,	
741	provided that the actual or alleged act, error, or omission did	
742	not result from intentional or willful and wanton misconduct on	
743	the part of such person.	
744	(3) To the extent not covered by the state involved, member	
745	state, or the Interstate Commission, the representatives or	
746	employees of the Interstate Commission shall be held harmless in	
747	the amount of a settlement or judgment, including attorney's	
748	fees and costs, obtained against such persons arising out of an	
749	actual or alleged act, error, or omission that occurred within	
750	the scope of Interstate Commission employment, duties, or	
751	responsibilities, or that such persons had a reasonable basis	
752	for believing occurred within the scope of Interstate Commission	
753	employment, duties, or responsibilities, provided that the	
754	actual or alleged act, error, or omission did not result from	
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755	intentional or willful and wanton misconduct on the part of such			
756				
757	persons.			
758				
59	SECTION 15			
60	RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION			
60	(a) The Interstate Commission shell promulante researching			
61 62	(a) The Interstate Commission shall promulgate reasonable			
	rules in order to effectively and efficiently achieve the			
63	purposes of the Compact. Notwithstanding the foregoing, in the			
64	event the Interstate Commission exercises its rulemaking			
65 65	authority in a manner that is beyond the scope of the purposes			
66	of the Compact, or the powers granted hereunder, then such an			
67	action by the Interstate Commission shall be invalid and have no			
68	force or effect.			
59	(b) Rules deemed appropriate for the operations of the			
70	Interstate Commission shall be made pursuant to a rulemaking			
71	process that substantially conforms to the "Model State			
72	Administrative Procedure Act" of 2010, and subsequent amendments			
73	thereto.			
74	(c) Not later than thirty (30) days after a rule is			
75	promulgated, any person may file a petition for judicial review			
76	of the rule in the United States District Court for the District			
77	of Columbia or the federal district where the Interstate			
78	Commission has its principal offices, provided that the filing			
79	of such a petition shall not stay or otherwise prevent the rule			
80	from becoming effective unless the court finds that the			
81	petitioner has a substantial likelihood of success. The court			
82	shall give deference to the actions of the Interstate Commission			
83	$\underline{\text{consistent}}$ with applicable law and shall not find the rule to be			
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 $\textbf{CODING:} \text{ Words } \frac{}{\text{stricken}} \text{ are deletions; words } \underline{\text{underlined}} \text{ are additions.}$ 

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784	unlawful if the rule represents a reasonable exercise of the			
785	authority granted to the Interstate Commission.			
786	authority granted to the interstate commission.			
787	SECTION 16			
788	OVERSIGHT OF INTERSTATE COMPACT			
789	<u></u>			
790	(a) The executive, legislative, and judicial branches of			
791	state government in each member state shall enforce the Compact			
792	and shall take all actions necessary and appropriate to			
793	effectuate the Compact's purposes and intent. The provisions of			
794	the Compact and the rules promulgated hereunder shall have			
795	standing as statutory law but shall not override existing state			
796	authority to regulate the practice of medicine.			
797	(b) All courts shall take judicial notice of the Compact			
798	and the rules in any judicial or administrative proceeding in a			
799	member state pertaining to the subject matter of the Compact			
800	which may affect the powers, responsibilities or actions of the			
801	Interstate Commission.			
802	(c) The Interstate Commission shall be entitled to receive			
803	all service of process in any such proceeding, and shall have			
804	standing to intervene in the proceeding for all purposes.			
805	Failure to provide service of process to the Interstate			
806	Commission shall render a judgment or order void as to the			
807	Interstate Commission, the Compact, or promulgated rules.			
808				
809	SECTION 17			
810	ENFORCEMENT OF INTERSTATE COMPACT			
811				
812	(a) The Interstate Commission, in the reasonable exercise			
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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		

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842	rules, the Interstate Commission shall:	
843	(1) Provide written notice to the defaulting state and	
844	other member states, of the nature of the default, the means of	
845	curing the default, and any action taken by the Interstate	
846	Commission. The Interstate Commission shall specify the	
847	conditions by which the defaulting state must cure its default;	
848	and	
849	(2) Provide remedial training and specific technical	
850	assistance regarding the default.	
851	(c) If the defaulting state fails to cure the default, the	
852	defaulting state shall be terminated from the Compact upon an	
853	affirmative vote of a majority of the Commissioners and all	
854	rights, privileges, and benefits conferred by the Compact shall	
855	terminate on the effective date of termination. A cure of the	
856	default does not relieve the offending state of obligations or	
857		
858	(d) Termination of membership in the Compact shall be	
859	imposed only after all other means of securing compliance have	
860	been exhausted. Notice of intent to terminate shall be given by	
861	the Interstate Commission to the governor, the majority and	
862	minority leaders of the defaulting state's legislature, and each	
863	of the member states.	
864	(e) The Interstate Commission shall establish rules and	
865	procedures to address licenses and physicians that are	
866	materially impacted by the termination of a member state, or the	
867	withdrawal of a member state.	
868	(f) The member state which has been terminated is	
869	responsible for all dues, obligations, and liabilities incurred	
870	through the effective date of termination including obligations,	
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871	the performance of which extends beyond the effective date of			
872	termination.			
873	(g) The Interstate Commission shall not bear any costs			
874	relating to any state that has been found to be in default or			
875	which has been terminated from the Compact, unless otherwise			
876	mutually agreed upon in writing between the Interstate			
877	Commission and the defaulting state.			
878	(h) The defaulting state may appeal the action of the			
879	Interstate Commission by petitioning the United States District			
880	Court for the District of Columbia or the federal district where			
881	the Interstate Commission has its principal offices. The			
882	prevailing party shall be awarded all costs of such litigation			
883	including reasonable attorney's fees.			
884				
885	SECTION 19			
886	DISPUTE RESOLUTION			
887				
	(a) The Interstate Commission shall attempt, upon the			
888	(a) The Interstate Commission shall attempt, upon the			
888 889	(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject			
889	request of a member state, to resolve disputes which are subject			
889 890	request of a member state, to resolve disputes which are subject to the Compact and which may arise among member states or member			
889 890 891	request of a member state, to resolve disputes which are subject to the Compact and which may arise among member states or member boards.			
889 890 891 892	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			
889 890 891 892 893	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			
889 890 891 892 893 894	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			
889 890 891 892 893 894 895	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.			
889 890 891 892 893 894 895 896	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. <u>SECTION 20</u>			
889 890 891 892 893 894 895 896 897	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. <u>SECTION 20</u>			
889 890 891 892 893 894 895 896 897 898	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. <u>SECTION 20</u> <u>MEMBER STATES, EFFECTIVE DATE AND AMENDMENT</u>			

	25-01035C-20 2020926				
900	Compact.				
901	(b) The Compact shall become effective and binding upon				
902	legislative enactment of the Compact into law by no less than				
903	seven (7) states. Thereafter, it shall become effective and				
904	binding on a state upon enactment of the Compact into law by				
905	that state.				
906	(c) The governors of non-member states, or their designees,				
907	shall be invited to participate in the activities of the				
908	Interstate Commission on a non-voting basis prior to adoption of				
909	the Compact by all states.				
910	(d) The Interstate Commission may propose amendments to the				
911	Compact for enactment by the member states. No amendment shall				
912	become effective and binding upon the Interstate Commission and				
913	the member states unless and until it is enacted into law by				
914	unanimous consent of the member states.				
915					
916	SECTION 21				
917	WITHDRAWAL				
918					
919	(a) Once effective, the Compact shall continue in force and				
920	remain binding upon each and every member state; provided that a				
921	member state may withdraw from the Compact by specifically				
922	repealing the statute which enacted the Compact into law.				
923	(b) Withdrawal from the Compact shall be by the enactment				
924	of a statute repealing the same, but shall not take effect until				
925	one (1) year after the effective date of such statute and until				
926	written notice of the withdrawal has been given by the				
927	withdrawing state to the governor of each other member state.				
928	(c) The withdrawing state shall immediately notify the				
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929				
930	introduction of legislation repealing the Compact in the			
931	withdrawing state.			
932	(d) The Interstate Commission shall notify the other member			
933	states of the withdrawing state's intent to withdraw within			
934	sixty (60) days of its receipt of notice provided under			
935	subsection (c).			
936	(e) The withdrawing state is responsible for all dues,			
937	obligations and liabilities incurred through the effective date			
938	of withdrawal, including obligations, the performance of which			
939	extend beyond the effective date of withdrawal.			
940	(f) Reinstatement following withdrawal of a member state			
941	shall occur upon the withdrawing state reenacting the Compact or			
942	upon such later date as determined by the Interstate Commission.			
943	(g) The Interstate Commission is authorized to develop			
944	rules to address the impact of the withdrawal of a member state			
945	on licenses granted in other member states to physicians who			
946	designated the withdrawing member state as the state of			
947	principal license.			
948				
949	SECTION 22			
950	DISSOLUTION			
951				
952	(a) The Compact shall dissolve effective upon the date of			
953	the withdrawal or default of the member state which reduces the			
954	membership in the Compact to one (1) member state.			
955	(b) Upon the dissolution of the Compact, the Compact			
956	becomes null and void and shall be of no further force or			
957	effect, and the business and affairs of the Interstate			
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958	Commission shall be concluded and surplus funds shall be			
959	distributed in accordance with the bylaws.			
960				
961	SECTION 23			
962	SEVERABILITY AND CONSTRUCTION			
963				
964	(a) The provisions of the Compact shall be severable, and			
965	if any phrase, clause, sentence, or provision is deemed			
966	unenforceable, the remaining provisions of the Compact shall be			
967	enforceable.			
968	(b) The provisions of the Compact shall be liberally			
969	construed to effectuate its purposes.			
970	(c) Nothing in the Compact shall be construed to prohibit			
971	the applicability of other interstate compacts to which the			
972	states are members.			
973				
974	SECTION 24			
975	BINDING EFFECT OF COMPACT AND OTHER LAWS			
976				
977	(a) Nothing herein prevents the enforcement of any other			
978	law of a member state that is not inconsistent with the Compact.			
979	(b) All laws in a member state in conflict with the Compact			
980	are superseded to the extent of the conflict.			
981	(c) All lawful actions of the Interstate Commission,			
982	including all rules and bylaws promulgated by the Commission,			
983	are binding upon the member states.			
984	(d) All agreements between the Interstate Commission and			
985	the member states are binding in accordance with their terms.			
986	(e) In the event any provision of the Compact exceeds the			
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987	constitutional limits imposed on the legislature of any member			
988	state, such provision shall be ineffective to the extent of the			
989	conflict with the constitutional provision in question in that			
990	member state.			
991	Section 8. Section 456.4502, Florida Statutes, is created			
992	to read:			
993	456.4502 Interstate Medical Licensure Compact; disciplinary			
994	proceedingsA physician licensed pursuant to chapter 458,			
995	chapter 459, or s. 456.4501 whose license is suspended or			
996	revoked by this state pursuant to the Interstate Medical			
997	Licensure Compact as a result of disciplinary action taken			
998	against the physician's license in another state shall be			
999	granted a formal hearing before an administrative law judge from			
1000	the Division of Administrative Hearings held pursuant to chapter			
1001	120 if there are any disputed issues of material fact. In such			
1002	proceedings:			
1003	(a) Notwithstanding s. 120.569(2), the department shall			
1004	notify the division within 45 days after receipt of a petition			
1005	or request for a formal hearing.			
1006	(b) The determination of whether the physician has violated			
1007	the laws and rules regulating the practice of medicine or			
1008	osteopathic medicine, as applicable, including a determination			
1009	of the reasonable standard of care, is a conclusion of law that			
1010	is to be determined by appropriate board, and is not a finding			
1011	of fact to be determined by an administrative law judge.			
1012	(c) The administrative law judge shall issue a recommended			
1013	order pursuant to chapter 120.			
1014	(d) The Board of Medicine or the Board of Osteopathic			
1015	Medicine, as applicable, shall determine and issue the final			
1				

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1016	order in each disciplinary case. Such order shall constitute		
1017	final agency action.		
1018	(e) Any consent order or agreed-upon settlement is subject		
1019	to the approval of the department.		
1020	(f) The department shall have standing to seek judicial		
1021	review of any final order of the board, pursuant to s. 120.68.		
1022	Section 9. Section 456.4504, Florida Statutes, is created		
1023	to read:		
1024	456.4504 Interstate Medical Licensure Compact RulesThe		
1025	department may adopt rules to implement the Interstate Medical		
1026	Licensure Compact.		
1027	Section 10. Paragraph (h) is added to subsection (10) of		
1028	section 768.28, Florida Statutes, to read:		
1029	768.28 Waiver of sovereign immunity in tort actions;		
1030	recovery limits; limitation on attorney fees; statute of		
1031	limitations; exclusions; indemnification; risk management		
1032	programs		
1033	(10)		
1034	(h) For the purposes of this section, the representative		
1035	appointed from the Board of Medicine and the representative		
1036	appointed from the Board of Osteopathic Medicine, when serving		
1037	as commissioners of the Interstate Medical Licensure Compact		
1038	Commission pursuant to s. 456.4501, and any administrator,		
1039	officer, executive director, employee, or representative of the		
1040	Interstate Medical Licensure Compact Commission, when acting		
1041	within the scope of their employment, duties, or		
1042	responsibilities in this state, are considered agents of the		
1043	state. The commission shall pay any claims or judgments pursuant		
1044	to this section and may maintain insurance coverage to pay any		
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Florida	Senate	-	2020
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1045 <u>such claims or judgments.</u>

1046 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.)

Prepare	ed By: The Pro	ofessional Staff of the Approp	oriations Subcommi	ttee on Health and Human Services
BILL:	CS/SB 10	94		
INTRODUCER:	Health Po	licy Committee and Sena	ator Diaz	
SUBJECT:	Consultar	nt Pharmacists		
DATE:	February	24, 2020 REVISED:		
ANAL	_YST	STAFF DIRECTOR	REFERENCE	ACTION
. Rossitto-V Winkle	an	Brown	HP	Fav/CS
2. Howard		Kidd	AHS	<b>Recommend: Favorable</b>
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

⁶ Section 465.009(6), F.S.

¹ American Association of Colleges of Pharmacy, *About AACP*, *available at* <u>https://www.aacp.org/about-aacp</u> (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.

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-thecounter 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:

 10  *Id*.

⁸ Section 465.003(13), F.S.

⁹ See s. 465.189, F.S.

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

²² Id.

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).

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

https://www.cdc.gov/dhdsp/pubs/docs/translational_tools_pharmacists.pdf (last visited Feb. 7, 2020).

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* 

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* <u>https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf</u> (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:

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).

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



The Florida Senate

# **Committee Agenda Request**

То:	Senator Aaron Bean, Chair Appropriations Subcommittee on Health and Human Services
Subject:	Committee Agenda Request
Date:	February 14, 2020

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

THE FLORID	A SENATE	
APPEARANO	E RECORD	
(Deliver BOTH copies of this form to the Senator or S	Senate Professional Staff conducting the meet	ing) $SB 1094$
Meeting Date		Bill Number (if applicable)
Topic Consultant Phanma Cists	Arr	endment Barcode (if applicable)
Name Joseph Salzverg (Sauls-Ver	()	
Job Title Attorney Cobby of		
Address 30 S. Brohough St. #600	Phone So	577-9090
Street V J FL	Sazo Email	
City State	Zip	2
Speaking: For Against Information	Waive Speaking: In (The Chair will read this infe	Support Against
Representing FL Society of Heal-	th System Pham	acists
Appearing at request of Chair: Yes No	_obbyist registered with Legis	slature: Yes 🗌 No

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

# THE FLORIDA SENATE APPEARANCE RECORD

February 25, 2020	(Deliver BOTH copies of this form to the Se	enator or Senate Professional S	taff conducting the meeting) $CS/SB$ [094
Meeting Date			Bill Number (if applicable)
Topic CONSULTAN	VT PHARMACISTU		Amendment Barcode (if applicable)
Name Michael Jackson	)		
Job Title <u>Executive Vice</u>	e President and CEO		
Address 610 North Ada	ams Street		Phone (850) 222-2400
Tallahassee	Florida	32301	Email mjackson@pharmview.com
City Speaking: For For	State		peaking: In Support Against ir will read this information into the record.)
Representing Flori	ida Pharmacy Association		
Appearing at request c	of Chair: 🗌 Yes 🗡 No	Lobbyist regist	ered 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.

APPEARAN	RIDA SENATE NCE RECORD r or Senate Professional Staff conducting the meet	ing) SB 1099 Bill Number (if applicable)
Topic	Am	endment Barcode (if applicable)
Name		
Job Title		
Address 1930 Piedmon Dr.E. Street Jallabajac H	Phone 25 <u>72708</u> Email (60	#@flmechog]. suy
City     State       Speaking:     For     Against     Information       Representing     Floridg     Medical	Zip Waive Speaking: In (The Chair will read this info	Support Against ormation into the record.)
Appearing at request of Chair: Yes No	Lobbyist registered with Legis	slature: 📝 Yes 🗌 No

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

THE FLORIDA SENATE APPEARANCE RECORD (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) Meeting Date SB 1094 Bill Number (if applicable)					
Topic	Amendment Barcode (if applicable)				
Name_ finee Diaz Lyon					
Job Title					
Address 119 South Monroe Street #200	Phone 850-205-9000				
Address 119 South Monroe Street #200 Street tallahassee FL 32301 City State Zip	Email amee diarbon Omhd in				
	peaking: In Support Against air will read this information into the record.)				
Representing the Florida Academy of	Family Physicians (FAFP)				
Appearing at request of Chair: Yes Lobbyist regist	tered with Legislature: Yes 🗌 No				

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

By the Committee on Health Policy; and Senator Diaz

588-03469-20 20201094c1 1 A bill to be entitled 2 An act relating to consultant pharmacists; amending s. 465.003, F.S.; revising the definition of the term 3 "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 8 perform specified services under certain conditions; ç prohibiting a consultant pharmacist from modifying or 10 discontinuing medicinal drugs prescribed by a health 11 care practitioner under certain conditions; revising 12 the responsibilities of a consultant pharmacist; 13 requiring a consultant pharmacist and a collaborating 14 practitioner to maintain collaborative practice 15 agreements; requiring collaborative practice 16 agreements to be made available upon request from or 17 upon inspection by the Department of Health; 18 prohibiting a consultant pharmacist from diagnosing 19 any disease or condition; defining the term "health 20 care facility"; providing an effective date. 21 22 Be It Enacted by the Legislature of the State of Florida: 23 24 Section 1. Subsection (13) of section 465.003, Florida 25 Statutes, is amended to read: 26 465.003 Definitions.-As used in this chapter, the term: 27 (13) "Practice of the profession of pharmacy" includes 2.8 compounding, dispensing, and consulting concerning contents, 29 therapeutic values, and uses of any medicinal drug; consulting Page 1 of 6

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

588-03469-20 20201094c1 30 concerning therapeutic values and interactions of patent or 31 proprietary preparations, whether pursuant to prescriptions or 32 in the absence and entirely independent of such prescriptions or 33 orders; and conducting other pharmaceutical services. For 34 purposes of this subsection, the term "other pharmaceutical 35 services" means the monitoring of the patient's drug therapy and 36 assisting the patient in the management of his or her drug 37 therapy, and includes reviewing, and making recommendations 38 regarding, review of the patient's drug therapy and health care 39 status in communication with the patient's prescribing health 40 care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or a similar statutory provision in 41 another jurisdiction, or such provider's agent or such other 42 43 persons as specifically authorized by the patient, regarding the 44 drug therapy. However, nothing in this subsection may not be 45 interpreted to permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the 46 initiation of any drug therapy, the practice of medicine, or the 47 48 practice of osteopathic medicine, unless otherwise permitted by 49 law. The term "practice of the profession of pharmacy" also includes any other act, service, operation, research, or 50 transaction incidental to, or forming a part of, any of the 51 52 foregoing acts, requiring, involving, or employing the science 53 or art of any branch of the pharmaceutical profession, study, or 54 training, and shall expressly permit a pharmacist to transmit 55 information from persons authorized to prescribe medicinal drugs 56 to their patients. The practice of the profession of pharmacy 57 also includes the administration of vaccines to adults pursuant to s. 465.189 and the preparation of prepackaged drug products 58

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i.	588-03469-20 20201094c1
59	in facilities holding Class III institutional pharmacy permits.
60	The term also includes ordering and evaluating any laboratory or
61	clinical testing; conducting patient assessments; and modifying,
62	discontinuing, or administering medicinal drugs pursuant to s.
63	465.0125 by a consultant pharmacist.
64	Section 2. Section 465.0125, Florida Statutes, is amended
65	to read:
66	465.0125 Consultant pharmacist license; application,
67	renewal, fees; responsibilities; rules
68	(1) The department shall issue or renew a consultant
69	pharmacist license upon receipt of an initial or renewal
70	application that which conforms to the requirements for
71	consultant pharmacist initial licensure or renewal as adopted
72	promulgated by the board by rule and a fee set by the board not
73	to exceed \$250. To be licensed as a consultant pharmacist, a
74	pharmacist must complete additional training as required by the
75	board.
76	(a) A consultant pharmacist may provide medication
77	management services in a health care facility within the
78	framework of a written collaborative practice agreement between
79	the pharmacist and a health care facility medical director or a
80	physician licensed under chapter 458 or chapter 459, a podiatric
81	physician licensed under chapter 461, or a dentist licensed
82	under chapter 466 who is authorized to prescribe medicinal
83	drugs. A consultant pharmacist may provide medication management
84	services, conduct patient assessments, and order and evaluate
85	laboratory or clinical testing only for patients of the health
86	care practitioner with whom the consultant pharmacist has a
87	written collaborative practice agreement.
1	

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	588-03469-20 20201094c1
88	(b) A written collaborative practice agreement must outline
89	the circumstances under which the consultant pharmacist may:
90	1. Order and evaluate any laboratory or clinical tests to
91	promote and evaluate patient health and wellness, and monitor
92	drug therapy and treatment outcomes.
93	2. Conduct patient assessments as appropriate to evaluate
94	and monitor drug therapy.
95	3. Modify or discontinue medicinal drugs as outlined in the
96	agreed-upon patient-specific order or preapproved treatment
97	protocol under the direction of a physician. However, a
98	consultant pharmacist may not modify or discontinue medicinal
99	drugs prescribed by a health care practitioner who does not have
100	a written collaborative practice agreement with the consultant
101	pharmacist.
102	4. Administer medicinal drugs.
103	(c) A The consultant pharmacist shall <u>maintain</u> be
104	responsible for maintaining all drug, patient care, and quality
105	assurance records as required by law and, with the collaborating
106	practitioner, shall maintain written collaborative practice
107	agreements that must be available upon request from or upon
108	inspection by the department.
109	(d) This subsection does not authorize a consultant
110	pharmacist to diagnose any disease or condition.
111	(e) For purposes of this subsection, the term "health care
112	facility" means an ambulatory surgical center or hospital
113	licensed under chapter 395, an alcohol or chemical dependency
114	treatment center licensed under chapter 397, an inpatient
115	hospice licensed under part IV of chapter 400, a nursing home
116	licensed under part II of chapter 400, an ambulatory care center
	Page 4 of 6
c	CODING: Words stricken are deletions; words underlined are additions.

588-03469-20 20201094c1 117 as defined in s. 408.07, or a nursing home component under 118 chapter 400 within a continuing care facility licensed under 119 chapter 651 for establishing drug handling procedures for the safe handling and storage of drugs. The consultant pharmacist 120 121 may also be responsible for ordering and evaluating any laboratory or clinical testing when, in the judgment of the 122 123 consultant pharmacist, such activity is necessary for the proper 124 performance of the consultant pharmacist's responsibilities. 125 Such laboratory or clinical testing may be ordered only with 126 regard to patients residing in a nursing home facility, and then 127 only when authorized by the medical director of the nursing home facility. The consultant pharmacist must have completed such 128 129 additional training and demonstrate such additional 130 qualifications in the practice of institutional pharmacy as 131 shall be required by the board in addition to licensure as a 132 registered pharmacist. 133 (2) Notwithstanding the provisions of subsection (1), a 134 consultant pharmacist or a doctor of pharmacy licensed in this 135 state may also be responsible for ordering and evaluating any 136 laboratory or clinical testing for persons under the care of a 137 licensed home health agency when, in the judgment of the 138 consultant pharmacist or doctor of pharmacy, such activity is 139 necessary for the proper performance of his or her 140 responsibilities and only when authorized by a practitioner 141 licensed under chapter 458, chapter 459, chapter 461, or chapter 142 466. In order for the consultant pharmacist or doctor of 143 pharmacy to qualify and accept this authority, he or she must 144 receive 3 hours of continuing education relating to laboratory and clinical testing as established by the board. 145 Page 5 of 6

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

588-03469-20

#### 20201094c1

- 146 (3) The board shall adopt promulgate rules necessary to
- 147 implement and administer this section.
- 148 Section 3. This act shall take effect July 1, 2020.

 $\label{eq:page 6 of 6} \mbox{CODING: Words stricken} \mbox{ are deletions; words } \underline{\mbox{ underlined }} \mbox{ are additions.}$ 

#### The Florida Senate BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared	d By: The Prof	essional Sta	aff of the Approp	oriations Subcommi	ttee on Health	and Human Services
BILL:	CS/SB 1206					
INTRODUCER:	Health Policy Committee and Senator Harrell					
SUBJECT:	Applied Behavior Analysis Services					
DATE:	February 2	4, 2020	REVISED:			
ANAL	YST	STAF	- DIRECTOR	REFERENCE		ACTION
. Kibbey		Brown		HP	Fav/CS	
. Gerbrandt		Kidd		AHS	Recomme	nd: Favorable
				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

 10  Id.

¹⁶ Id.

⁹ Id.

¹¹ TEACH Make a Difference, *What is Applied Behavior Analysis (ABA)?*, <u>https://teach.com/online-ed/psychology-degrees/what-is-aba/</u> (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).

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 <u>https://www.bacb.com/</u> (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.

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



## 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,

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

THE FLORIDA SENATE	
APPEARANCE RECO	RD
2-2.5-20 Meeting Date (Deliver BOTH copies of this form to the Senator or Senate Professional S	Staff conducting the meeting) Bill Number (if applicable)
Topic Applied Behavior ANALysis SERVICES	Amendment Barcode (if applicable)
Name Dr. Steve Cdeman	
Job Title Public Policy Director	
Address 3116 CApital Circle, NE.	Phone 904-635-7155
Street TALLALAFSEE FL 32308 City State Zip	Email STEVE_ CO/EMAN StabAwarld
	peaking: In Support Against
Representing FloridA Association for BELAVIS	or Awalysis
Appearing at request of Chair: Yes No Lobbyist regis	tered with Legislature: Yes No

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

THE FLOR	IDA SENATE		
APPEARAN	CE RECOR	D	
$\frac{2 25 2020}{Meeting Date}$ (Deliver BOTH copies of this form to the Senator of	or Senate Professional Stat	f conducting the meeting)	SB 1206
weening Date			Bill Number (if applicable)
TOPIC APPLIED BELIANOR ANAMSIS SERVICE	5	Amendr	ment Barcode (if applicable)
Name MARTA T. TIKI' FIOL			
Job Title			
Address 1658 DAVIS DR. Street		Phone 321.96	1-7831
City State	32952 Zip	Email_file: field	1 Cgmail.com
Speaking: For Against Information		eaking: In Sup	
Representing FLORIDA ASSOCIATION JA	BEHAVIOR AND	mysis	
Appearing at request of Chair: Yes Ano	Lobbyist registe	red with Legislatu	Ire: Yes No

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

THE FLORIDA SENATE         APPEARANCE RECO         Deliver BOTH copies of this form to the Senator or Senate Professional S         Meeting Date	
Topic <u>SB 1266</u> ABA	Amendment Barcode (if applicable)
Name Carolyn D'connell	
Job Title Duner Oconnell Behavioral Services	
Address <u>5432</u> Rattlesnake Hammock Kd	Phone <u>39-316-7656</u>
Naples FC 34113 City State Zip	Email <u>Coconnello connellocharior</u>
Speaking: For Against Information Waive Speaking: (The Cha	ceaking: In Support Against ir will read this information into the record.)
Representing	
Appearing at request of Chair: Yes No Lobbyist regist	ered with Legislature: 🗌 Yes 📐 No

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

THE FLORIDA SENATE						
APPEARANCE RECORD						
$\frac{2-35-3030}{Meeting Date}$ (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) $\frac{58120}{Bill Number (if applicable)}$						
Topic <u>Applied Behavior Analysis</u> , Amendment Barcode (if applicable) Name <u>Marucci</u> ( <u>Maru-chi</u> ) Guzman						
Name Marucci (Ma-ru-chi) Guzman						
Job Title President / Co-Founder						
Address 3271 S. ChickgSque Trail Phone 407 9680062						
$\frac{Sireer}{Orlando} = \sqrt{-C} = \frac{32809}{Zip} \text{ Email}$						
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						

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

THE FLORIDA SENATE						
APPEARANCE RECORD						
$\frac{\cancel{3}-25-2000}{Meeting Date}$ (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) $\frac{58}{Bill Number (if applicable)}$						
Topic Applied Behavior Analysis Amendment Barcode (if applicable)						
Name Marytza Sanz						
Job Title President/CEO						
Address 9219 Everwood St Phone 407 925 1544						
Orlando FL 32825Email						
City State Zip						
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 XNo Lobbyist registered with Legislature: Yes XNo						

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

20201206c1

By the Committee on Health Policy; and Senator Harrell

20201206c1 588-03101-20 588-03101-20 A bill to be entitled 1 30 must be established by rule and, for behavior analysts, must 2 An act relating to applied behavior analysis services; 31 include criteria for scope of practice, gualifications for amending s. 393.17, F.S.; authorizing the Agency for 32 certification, including training and testing requirements, 3 Persons with Disabilities to establish a certification 33 continuing education requirements for ongoing certification, and process for registered behavior technicians; requiring standards of performance. The procedures must also include 34 the agency to recognize the certification of 35 decertification procedures that may be used to determine whether registered behavior technicians awarded by a nonprofit 36 an individual continues to meet the qualifications for corporation that meets specified requirements; 37 certification or the professional performance standards and, if ç not, the procedures necessary to decertify an employee or amending s. 400.9905, F.S.; providing an exemption 38 10 from licensure requirements for certain individuals 39 service provider. 11 who are employed or under contract with certain 40 (2) The agency shall recognize the certification of 12 behavior analysts and registered behavior technicians awarded by entities providing applied behavior analysis services; 41 13 amending s. 1003.572, F.S.; revising the definition of a nonprofit corporation that adheres to the national standards 42 14 the term "private instructional personnel" to include 43 of boards that determine professional credentials and whose 15 certain registered behavior technicians; amending ss. 44 mission is to meet professional credentialing needs identified 16 456.47, 627.6686, and 641.31098, F.S.; conforming by behavior analysts, state governments, and consumers of 45 17 provisions to changes made by the act; providing an behavior analysis services. The certification procedure 46 18 effective date. recognized by the agency must undergo regular psychometric 47 19 48 review and validation, pursuant to a job analysis survey of the 20 Be It Enacted by the Legislature of the State of Florida: 49 profession and standards established by content experts in the 21 50 field. 22 Section 1. Section 393.17, Florida Statutes, is amended to 51 Section 2. Paragraph (o) is added to subsection (4) of 23 read: 52 section 400.9905, Florida Statutes, to read: 24 393.17 Behavioral programs; certification of behavior 53 400.9905 Definitions.-25 analysts and registered behavior technicians .-54 (4) "Clinic" means an entity where health care services are 26 (1) The agency may establish a certification process for 55 provided to individuals and which tenders charges for 27 behavior analysts and registered behavior technicians in order 56 reimbursement for such services, including a mobile clinic and a 2.8 to ensure that only qualified employees and service providers 57 portable equipment provider. As used in this part, the term does 29 provide behavioral analysis services to clients. The procedures not include and the licensure requirements of this part do not 58 Page 1 of 5 Page 2 of 5 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

	588-03101-20 20201206c1			588-03101-20 20201206c1
59	apply to:		88	456.47 Use of telehealth to provide services
60	(o) A group of individuals certified as behavior analysts		89	(1) DEFINITIONSAs used in this section, the term:
61	under s. 393.17, or licensed under chapter 490 or chapter 491,		90	(b) "Telehealth provider" means any individual who provides
62	and who are employed by or under contract with a group practice,		91	health care and related services using telehealth and who is
63	a billing provider, or an agency that provides applied behavior		92	licensed or certified under s. 393.17 as a behavior analyst;
64	analysis services as defined in ss. 627.6686 and 641.31098.		93	part III of chapter 401; chapter 457; chapter 458; chapter 459;
65			94	chapter 460; chapter 461; chapter 463; chapter 464; chapter 465;
66	Notwithstanding this subsection, an entity shall be deemed a		95	chapter 466; chapter 467; part I, part III, part IV, part V,
67	clinic and must be licensed under this part in order to receive		96	part X, part XIII, or part XIV of chapter 468; chapter 478;
68	reimbursement under the Florida Motor Vehicle No-Fault Law, ss.		97	chapter 480; part II or part III of chapter 483; chapter 484;
69	627.730-627.7405, unless exempted under s. 627.736(5)(h).		98	chapter 486; chapter 490; or chapter 491; who is licensed under
70	Section 3. Present paragraphs (b) through (f) of subsection		99	a multistate health care licensure compact of which Florida is a
71	(1) of section 1003.572, Florida Statutes, are redesignated as		100	member state; or who is registered under and complies with
72	paragraphs (c) through (g), respectively, a new paragraph (b) is		101	subsection (4).
73	added to that subsection, and paragraph (a) of that subsection		102	Section 5. Paragraph (b) of subsection (3) of section
74	is republished, to read:		103	627.6686, Florida Statutes, is amended to read:
75	1003.572 Collaboration of public and private instructional		104	627.6686 Coverage for individuals with autism spectrum
76	personnel		105	disorder required; exception
77	(1) As used in this section, the term "private		106	(3) A health insurance plan issued or renewed on or after
78	instructional personnel" means:		107	April 1, 2009, shall provide coverage to an eligible individual
79	(a) Individuals certified under s. 393.17 or licensed under		108	for:
80	chapter 490 or chapter 491 for applied behavior analysis		109	(b) Treatment of autism spectrum disorder and Down syndrome
81	services as defined in ss. 627.6686 and 641.31098.		110	through speech therapy, occupational therapy, physical therapy,
82	(b) Registered behavior technicians certified under s.		111	and applied behavior analysis. Applied behavior analysis
83	393.17 who practice under the supervision of a professional		112	services shall be provided by an individual certified $\underline{as \ a}$
84	authorized under paragraph (a) and who assist and support such		113	behavior analyst pursuant to s. 393.17 or an individual licensed
85	professional in providing applied behavior analysis services.		114	under chapter 490 or chapter 491.
86	Section 4. Paragraph (b) of subsection (1) of section		115	Section 6. Paragraph (b) of subsection (3) of section
87	456.47, Florida Statutes, is amended to read:		116	641.31098, Florida Statutes, is amended to read:
	Page 3 of 5			Page 4 of 5
<b>CODING:</b> Words stricken are deletions; words underlined are additions.				CODING: Words stricken are deletions; words underlined are additions.

	588-03101-20 20201206c1					
117	641.31098 Coverage for individuals with developmental					
118	disabilities					
119	(3) A health maintenance contract issued or renewed on or					
120	after April 1, 2009, shall provide coverage to an eligible					
121	individual for:					
122	(b) Treatment of autism spectrum disorder and Down					
123	syndrome, through speech therapy, occupational therapy, physical					
124	therapy, and applied behavior analysis services. Applied					
125	behavior analysis services shall be provided by an individual					
126	certified as a behavior analyst pursuant to s. 393.17 or an					
127	individual licensed under chapter 490 or chapter 491.					
128	Section 7. This act shall take effect July 1, 2020.					
i	Page 5 of 5					
	-					
<b>CODING:</b> Words stricken are deletions; words <u>underlined</u> are additions.						

# The Florida Senate BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepare	d By: The Pr	ofessional Sta	ff of the Approp	priations Subcommi	ttee on Health	and Human Services		
BILL:	CS/SB 1296							
INTRODUCER:	CER: Health Policy Committee; and Senators Berman and Rodriguez							
SUBJECT:	Health Access Dental Licenses							
DATE:	February	24, 2020	REVISED:					
ANAL	YST	STAFF	DIRECTOR	REFERENCE		ACTION		
. Rossitto-Va Winkle	an	Brown		HP	Fav/CS			
. Howard		Kidd		AHS	Recomme	nd: Favorable		
S.				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. DOErecognized 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 license² in order to attract out-ofstate 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 <u>https://floridasdentistry.gov/licensing/health-access-dentist/</u> (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 not authorized to practice 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.

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

$\frac{2125/20}{Meeting Date}$ (Deliver BOTH copies of this form to the Senator or Senate Professional	
Topic Health Access Dental Licenses	Amendment Barcode (if applicable)
Name tric Stern	_
Job Title Legislative Committee Menber	
Address 1747 Orlando Central PKWY	_ Phone <u>800-373-5782</u>
Orknob Fl 32809 City State Zip	_ Email
Speaking: For Against Information Waives	Speaking: In Support Against mair will read this information into the record.)
Representing Florida PTA	
Appearing at request of Chair: Yes No Lobbyist regi	stered with Legislature: 🔄 Yes 🚺 No

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

THE FLORIDA SENATE	
APPEARANCE RECO	RD
2 25 20 (Deliver BOTH copies of this form to the Senator or Senate Professional S	
Meeting Date	Bill Number (if applicable)
Topic Health Access Dental License	Amendment Barcode (if applicable)
Name Uce Anne Hart	
Job Title Chief Legislative Officer	
Address 118 Ei Jeffersn St	Phone 850. 224. 1089
Street <u>Tallabasseq</u> E 32301 City State Zip	Email jaharte floridadutal og
Speaking: 🗹 For 🗌 Against 🔄 Information Waive S	peaking: In Support Against
Representing Florida Dontal Associa	ition
Appearing at request of Chair: Yes XNo Lobbyist regist	tered with Legislature: 💢 Yes 🦳 No

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

CS for SB 1296

By the Committee on Health Policy; and Senator Berman

588-02263-20 20201296c1 588-02263-20 20201296c1 1 A bill to be entitled 30 fee. The fees specified in this subsection may not differ from 2 An act relating to health access dental licenses; 31 an applicant seeking licensure pursuant to s. 466.006; reviving, reenacting, and amending s. 466.0067, F.S., 32 (3) Has not been convicted of or pled nolo contendere to, 3 relating to the application for a health access dental regardless of adjudication, any felony or misdemeanor related to 33 license; reviving, reenacting, and amending s. 34 the practice of a health care profession; 466.00671, F.S., relating to the renewal of such 35 (4) Submits proof of graduation from a dental school license; reviving and reenacting s. 466.00672, F.S., 36 accredited by the Commission on Dental Accreditation of the relating to the revocation of such license; providing 37 American Dental Association or its successor agency; an effective date. ç 38 (5) Submits documentation that she or he has completed, or 10 39 will obtain before prior to licensure, continuing education 11 Be It Enacted by the Legislature of the State of Florida: 40 equivalent to this state's requirement for dentists licensed 12 41 under s. 466.006 for the last full reporting biennium before 13 applying for a health access dental license; Section 1. Notwithstanding the January 1, 2020, repeal of 42 14 section 466.0067, Florida Statutes, that section is revived, 43 (6) Submits proof of her or his successful completion of 15 reenacted, and amended to read: parts I and II of the dental examination by the National Board 44 16 466.0067 Application for health access dental license.-The of Dental Examiners and a state or regional clinical dental 45 Legislature finds that there is an important state interest in licensing examination that the board has determined effectively 17 46 18 attracting dentists to practice in underserved health access 47 measures the applicant's ability to practice safely; 19 settings in this state and further, that allowing out-of-state 48 (7) Currently holds a valid, active, dental license in good 20 dentists who meet certain criteria to practice in health access 49 standing from another of the United States, the District of 21 Columbia, or a United States territory which has not been settings without the supervision of a dentist licensed in this 50 22 state is substantially related to achieving this important state 51 revoked, suspended, restricted, or otherwise disciplined from 23 interest. Therefore, notwithstanding the requirements of s. 52 another of the United States, the District of Columbia, or a 24 466.006, the board shall grant a health access dental license to United States territory; 53 25 practice dentistry in this state in health access settings as 54 (8) Has never had a license revoked from another of the 26 defined in s. 466.003 to an applicant who that: 55 United States, the District of Columbia, or a United States 27 (1) Files an appropriate application approved by the board; 56 territorv; 2.8 (2) Pays an application license fee for a health access 57 (9) Has never failed the examination specified in s. 29 dental license, laws-and-rule exam fee, and an initial licensure 58 466.006, unless the applicant was reexamined pursuant to s. Page 1 of 5 Page 2 of 5 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

CS for SB 1296

1	588-02263-20 20201296c1		588-02263-20 20201296c1
59	466.006 and received a license to practice dentistry in this	88	regardless of adjudication, any felony or misdemeanor related to
60	state;	89	the practice of a health care profession;
61	(10) Has not been reported to the National Practitioner	90	
62	Data Bank, unless the applicant successfully appealed to have	91	specified herein may not differ from the renewal fee adopted by
63	his or her name removed from the data bank;	92	the board pursuant to s. 466.013. The department may provide
64	(11) Submits proof that he or she has been engaged in the	93	payment for these fees through the dentist's salary, benefits,
65	active, clinical practice of dentistry providing direct patient	94	or other department funds;
66	care for 5 years immediately preceding the date of application,	95	(d) Has not failed the examination specified in s. 466.006
67	or in instances when the applicant has graduated from an	96	since initially receiving a health access dental license or
68	accredited dental school within the preceding 5 years, submits	97	since the last renewal; and
69	proof of continuous clinical practice providing direct patient	98	(e) Has not been reported to the National Practitioner Data
70	care since graduation; and	99	Bank, unless the applicant successfully appealed to have his or
71	(12) Has passed an examination covering the laws and rules	100	her name removed from the data bank.
72	of the practice of dentistry in this state as described in s.	101	(2) The board may undertake measures to independently
73	466.006(4)(a).	102	verify the health access dental licensee's ongoing employment
74	Section 2. Notwithstanding the January 1, 2020, repeal of	103	status in the health access setting.
75	section 466.00671, Florida Statutes, that section is revived,	104	Section 3. Notwithstanding the January 1, 2020, repeal of
76	reenacted, and amended to read:	105	section 466.00672, Florida Statutes, that section is revived and
77	466.00671 Renewal of the health access dental license	106	reenacted to read:
78	(1) A health access dental licensee shall apply for renewal	107	466.00672 Revocation of health access dental license
79	each biennium. At the time of renewal, the licensee shall sign a	108	(1) The board shall revoke a health access dental license
80	statement that she or he has complied with all continuing	109	upon:
81	education requirements of an active dentist licensee. The board	110	(a) The licensee's termination from employment from a
82	shall renew a health access dental license for an applicant $\underline{who}$	111	qualifying health access setting;
83	that:	112	(b) Final agency action determining that the licensee has
84	(a) Submits documentation, as approved by the board, from	113	violated any provision of s. 466.027 or s. 466.028, other than
85	the employer in the health access setting that the licensee has	114	infractions constituting citation offenses or minor violations;
86	at all times pertinent remained an employee;	115	or
87	(b) Has not been convicted of or pled nolo contendere to,	116	(c) Failure of the Florida dental licensure examination.
	Page 3 of 5		Page 4 of 5
c	CODING: Words stricken are deletions; words <u>underlined</u> are additions.		CODING: Words stricken are deletions; words <u>underlined</u> are additions.

Florida Senate - 2020

CS for SB 129	CS	for	SB	1296
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588-0	02263-20 2020	1296c1
.7	(2) Failure of an individual licensed pursuant to s.	
.8 466.0	0067 to limit the practice of dentistry to health acces	s
9 sett	ings as defined in s. 466.003 constitutes the unlicense	d
0 pract	tice of dentistry.	
1	Section 4. This act shall take effect upon becoming a	law.
	Page 5 of 5	

# 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:	11 1	tions Subcommittee on H e; and Senators Wright, H		n Services; Banking and Insurance ez, and Perry	
SUBJECT:	Prescriptio	on Drug Coverage			
DATE:	February	26, 2020 REVISED:			
ANAL	YST	STAFF DIRECTOR	REFERENCE	ACTION	
. Johnson		Knudson	BI	Fav/CS	
. Gerbrandt		Kidd	AHS	<b>Recommend: Fav/CS</b>	
			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

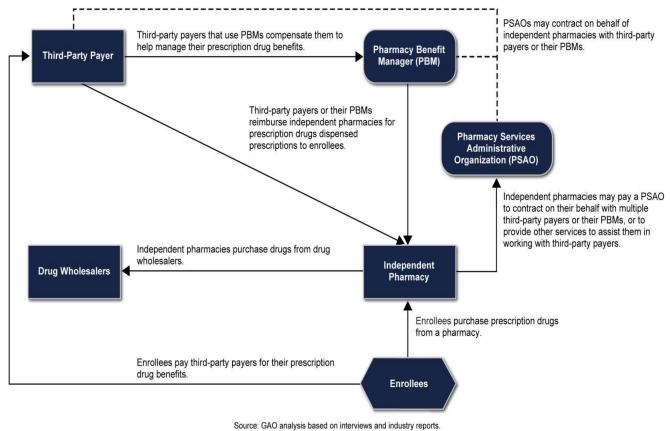
The affordability of prescription drugs has gained attention at the state and federal level. In recent years, PBMs and drug manufacturers have come under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Many stakeholders (drug manufacturers, drug wholesalers, 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, <u>https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf</u> (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).

 $[\]overset{\sim}{4}$  Id.



#### A Study of 15 Large Employer Plans⁵

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 <u>https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/reducing-wasteful-spending-employers-pharmacy-benefit-plans</u> (last viewed Feb. 12, 2020).

The report⁶ 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 costsharing 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 pharmacies¹² 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 report¹⁴ 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 pharmacies peaked in 2017 at 1,735, and declined to 1,541 in 2019.¹⁵

¹¹ Drug Channels, CVS, Express Scripts, and the Evolution of the PBM Business Model (May 29, 2019) at <u>https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html</u> (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* <u>https://www.pharmacist.com/sites/default/files/files/Profile_16_Independent_SDS_FINAL_090307.pdf</u> (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 pharmacies¹⁷ 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;

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.

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 <a href="http://www.gao.gov/assets/660/651631.pdf">http://www.gao.gov/assets/660/651631.pdf</a> (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 <u>https://www.cnn.com/2019/11/15/tech/amazon-pharmacy-pillpack/index.html</u> (last viewed Jan. 22, 2020).

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 <u>https://www.managedhealthcareexecutive.com/drug-costs/your-pbms-mac-list-impacts-your-bottom-line</u> (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 <u>https://apps.fldfs.com/eservice/MedicalProvider.aspx</u> (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 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

³⁷ Id.

³³ See Department of Management Services, 2020 Legislative Analysis of SB 1338 (Jan. 16, 2020).

³⁴ Id.

³⁵ Id.

³⁶ 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 <u>https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not</u> (last viewed Jan. 3, 2020).

⁴⁰ *Id*.

⁴¹Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors* (May 15, 2019) <u>https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf</u> (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 regulations⁴⁴ 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 <u>https://legislature.vermont.gov/Documents/2016/Docs/ACTS/ACT165/ACT165%20Act%20Summary.pdf</u> (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.

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.

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.

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

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

1338

Meeting Date			Bill Number (if applicable)
Topic Prescription Drug Coverage	9		Amendment Barcode (if applicable)
Name Barney Bishop III			
Job Title CEO		~~~~	
Address 2215 Thomasville Road			Phone 850.510.9922
Street			
Tallahassee	FL	32308	Email barney@barneybishop.com
<i>City</i> Speaking: For Against	State	^{Zip} Waive S (The Cha	peaking: In Support Against ir will read this information into the record.)
Representing Florida Smart Ju	ustice Alliance		
Appearing at request of Chair:	Yes 🖌 No	Lobbyist regist	ered with Legislature: 🗹 Yes 🗌 No
While it is a Sonate tradition to oncourage	a public testimony tin	no may not normit all	persons wishing to speak to be heard at this

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25 Feb 20

2-25-20 (Deliver BOTH copies of this form to the Senator Meeting Date	or Senate Professional Staff conducting the meeting) <u>56 1338</u> Bill Number (if applicable)
Topic PBM	Amendment Barcode (if applicable)
Name Share Abbott Share Abbott	
Job Title Pharmacirk	
Address 1061 S 2 nd Street	Phone 850-333-0747
Defuniak Springs FL City State	Zip Email NFRX98 Daol. 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 Yo	Lobbyist registered with Legislature: Yes Yo

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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2/18/20 Meeting Date	(Deliver BOTH copies of this form to the Senator or Se	enate Professional Staff conducting the r	neeting) <u>133</u> Bill Number (if applicable)
Торіс			Amendment Barcode (if applicable)
Name Chris	Nuland		
Job Title			
Address <u>4427</u>	Herrchel Street	Phone 90	27-233-3051
Street Jacksonvi City	lle, FL 32210 State	Email	land law e act.com
Speaking: For	Against Information	Waive Speaking: 🗾	In Support Against information into the record.)
Representing	Ioricla Gastroenterologic	Society	
Appearing at request	of Chair: Yes No Lo	obbyist registered with Le	gislature: 📈 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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Topic	Amendment Barcode (if applicable)
Name JEFF Kottkamp	
Job Title	
Address	Phone
Street <u> <u> </u> </u>	Email
Speaking: For Against Information	Waive Speaking: In Support Against (The Chair will read this information into the record.)
Representing Small Business PHARMICIES AI	ligned for Reform
Appearing at request of Chair: Yes No Lobby	ist registered with Legislature: Yes 🗌 No

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THE FLORIDA SENATE	
APPEARANCE RECO (Deliver BOTH copies of this form to the Senator or Senate Professional St Meeting Date	
TopicPBM	Amendment Barcode (if applicable)
Name AIEX HERWIG	
Job Title PharmAcIST	
Address 43 EAST AVE	Phone
Street MAPLES FL 34/08 City State Zip	Email <u>AIEXagyIFshoRERX,Coly</u>
	beaking: In Support Against ir will read this information into the record.)
Representing SPAR SMALL BUSINESS Phace	MACIES GLIJNED FOR REFORM
Appearing at request of Chair: Yes 📈 No Lobbyist register	ered with Legislature: 🗌 Yes 💢 No

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$\begin{array}{c} \textbf{APPEARAN} \\ \hline \\ $			1338
Meeting Date			Bill Number (if applicable)
Topic PBMs + Medicaid	/	Amend	ment Barcode (if applicable)
Name Keun Duane			
Job Title Pharmacist			(a - F(1))
Address 2577 Karatas CE		Phone $\underline{709-9}$	122-5643
Street Sacksonville FL City State	<u>32246</u> Zip	Email KSD	vaneCyman (Ca
City State Speaking: For Against Information	, Waive Sj	peaking: In Su	
Representing SPAR	(The Cha		
Appearing at request of Chair: Yes No	Lobbyist regist	tered with Legislat	
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THE FLORIDA SENATE	
APPEARANCE RE	CORD
22520 Meeting Date (Deliver BOTH copies of this form to the Senator or Senate Profess	sional Staff conducting the meeting)          I33         Bill Number (if applicable)
Topic Prescription Drug Coverage	Amendment Barcode (if applicable)
Name John O'Brien	
Job Title	
Address <u>150 N. Tamiani Tri</u>	Phone
Sarasta FL 342 City State Zip	39 Email
	ive Speaking: In Support Against e Chair will read this information into the record.)
Representing Florida Pharmacy Association	0M
Appearing at request of Chair: Yes 📉 No Lobbyist r	egistered with Legislature: 🗌 Yes 🔀 No

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1338

M	eeting Date			Bill Number (if applicable)
Topic	Prescription Drug	Coverage/PBM Reform		Amendment Barcode (if applicable)
Name	Michael Fischer			
Job Tit	le			
Addres	201 S. Monroe	, 5th Floor		Phone 850-329-6165
	Street TLH	FL	32301	Email mike@legisgroupfl.com
Speaki	City ng: 🖌 For 🚺	State		peaking: In Support Against ir will read this information into the record.)
Rej	presenting Florida	a Independent Pharmacy	Network	
Appea	ring at request of	Chair: Yes 🗹 No	Lobbyist regist	ered with Legislature: Ves No
				persons wishing to speak to be heard at this persons as possible can be heard.

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2-25-20

THE FLORIDA SENATE	
APPEARANCE REC	ORD
(Deliver BOTH copies of this form to the Senator or Senate Profession Meeting Date	bill Number (if applicable)
Topic Prescription Drug Caveage	Amendment Barcode (if applicable)
Name_Scott Woods	
Job Title Assistant Vice President, State Affairs	
Address 325 7th StNW, 9th Floor	Phone 202-756-5736
Washington DC 20004 City State Zip	Email_Swoods@pcmanet.org
	e Speaking: In Support Against Chair will read this information into the record.)
Representing Pharmaceutical Care Management	+ Association
Appearing at request of Chair: Yes V No Lobbyist reg	gistered with Legislature: Ves 🗌 No

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S-001 (10/14/14)

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February 2	5, 2020	opies of this form to the Senator	or Senate Professional St	taff conducting the meeting) CS/SB 1338 Bill Number (if applicable)
	RESCRIPTION DRI	JE COVENAGE		Amendment Barcode (if applicable)
	nael Jackson			· · · · · · · · · · · · · · · · · · ·
Job Title _	xecutive Vice President	and CEO		
Address	10 North Adams Street			Phone (850) 222-2400
	eet allahassee	Florida	32301	Email mjackson@pharmview.com
<i>Cit</i> Speaking:	y For Against	State		peaking: In Support Against ir will read this information into the record.)
Represe	enting Florida Pharma	cy Association		
Appearing	at request of Chair:	Yes 🔀 No	Lobbyist regist	ered 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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SB1338

Meeting Date				Bill Number (if applie	cable)
Topic Prescription	n Drug Coverage	)		Amendment Barcode (if appl	icable)
Name David Poole	e				
Job Title Director	Legislative Affair	ſS			
Address 1825 Co	untry Club Dr			Phone 850-766-3323	
Tallahass	see	FL	32301	Email david.poole@aidshealth.org	
City Speaking: Fo	r Against	State		beaking: In Support Agains	
Representing	AIDS Healthca	re Foundation (AHF)			
Appearing at requ	lest of Chair:	Yes 🖌 No	Lobbyist registe	ered 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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Meeting Date				Bill Number (if applicable)
Topic <u>Pharman</u>	y V			Amendment Barcode (if applicable)
Name lighthua	Henderson	\		
Job Title				
Address			Phone _	850559082)
Street			Email	Ciphenderson D
City	State	Zip		, Me. con
Speaking: For Agair	nst Information	Waive Sp (The Cha	beaking: ) ir will read	In Support Against
Representing 2P				
Appearing at request of Cha	ir: Yes No	Lobbyist regist	ered with	Legislature: 📈 Yes 🦳 No

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S-001 (10/14/14)

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 $\boldsymbol{B}\boldsymbol{y}$  the Committee on Banking and Insurance; and Senators Wright and Harrell

597-02766-20 20201338c1 1 A bill to be entitled 2 An act relating to prescription drug coverage; amending s. 624.3161, F.S.; authorizing the Office of 3 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 ç requirements and restrictions apply; authorizing 10 audited pharmacies to appeal certain findings; 11 providing that health insurers and health maintenance 12 organizations that transfer a certain payment 13 obligation to pharmacy benefit managers remain 14 responsible for certain violations; creating s. 15 624.492, F.S.; providing applicability; requiring 16 health insurers and health maintenance organizations, 17 or pharmacy benefit managers on behalf of health 18 insurers and health maintenance organizations, to 19 annually report specified information to the office; 20 requiring reporting pharmacy benefit managers to also 21 provide the information to health insurers and health 22 maintenance organizations they contract with; 23 authorizing the Financial Services Commission to adopt 24 rules; amending ss. 627.64741, 627.6572, and 641.314, 2.5 F.S.; defining and redefining terms; specifying 26 requirements relating to brand-name and generic drugs 27 in contracts between pharmacy benefit managers and 28 pharmacies or pharmacy services administration 29 organizations; requiring an agreement for pharmacy Page 1 of 18 CODING: Words stricken are deletions; words underlined are additions.

597-02766-20 20201338c1 30 benefit managers to pass through certain financial 31 benefits to the individual or group health insurer or 32 health maintenance organization, respectively; 33 authorizing the office to require health insurers or 34 health maintenance organizations to submit certain 35 contracts or contract amendments to the office; 36 authorizing the office to order insurers or health 37 maintenance organizations to cancel such contracts 38 under certain circumstances; authorizing the 39 commission to adopt rules; revising applicability; 40 providing an effective date. 41 Be It Enacted by the Legislature of the State of Florida: 42 43 44 Section 1. Subsections (1) and (3) of section 624.3161, Florida Statutes, are amended to read: 45 46 624.3161 Market conduct examinations.-47 (1) As often as it deems necessary, the office shall 48 examine each pharmacy benefit manager, each licensed rating 49 organization, each advisory organization, each group, association, carrier, as defined in s. 440.02, or other 50 organization of insurers which engages in joint underwriting or 51 52 joint reinsurance, and each authorized insurer transacting in 53 this state any class of insurance to which the provisions of 54 chapter 627 are applicable. The examination shall be for the 55 purpose of ascertaining compliance by the person examined with 56 the applicable provisions of chapters 440, 624, 626, 627, and 57 635. 58 (3) The examination may be conducted by an independent Page 2 of 18

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amended to read:

consents otherwise.

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20201338c1 597-02766-20 20201338c1 to 24 months after the date a claim is submitted to or professional examiner under contract to the office, in which 88 case payment shall be made directly to the contracted examiner 89 adjudicated by the entity. by the insurer or person examined in accordance with the rates 90 (d) To have An audit that requires clinical or professional and terms agreed to by the office and the examiner. 91 judgment must be conducted by or in consultation with a Section 2. Section 465.1885, Florida Statutes, is 92 pharmacist. transferred, renumbered as s. 624.491, Florida Statutes, and 93 (e) A pharmacy may To use the written and verifiable 94 records of a hospital, physician, or other authorized 624.491 465.1885 Pharmacy audits; rights.-95 practitioner, which are transmitted by any means of (1) A health insurer or health maintenance organization communication, to validate the pharmacy records in accordance 96 providing pharmacy benefits through a major medical individual 97 with state and federal law. or group health insurance policy or health maintenance contract, 98 (f) A pharmacy must To be reimbursed for a claim that was respectively, shall comply with the requirements of this section 99 retroactively denied for a clerical error, typographical error, when the insurer or health maintenance organization or any scrivener's error, or computer error if the prescription was 100 entity acting on behalf of the insurer or health maintenance 101 properly and correctly dispensed, unless a pattern of such organization, including, but not limited to, a pharmacy benefit 102 errors exists, fraudulent billing is alleged, or the error manager, audits the records of a pharmacy licensed under chapter 103 results in actual financial loss to the entity. 465. Such audit must comply with the following requirements If 104 (q) A copy of To receive the preliminary audit report must an audit of the records of a pharmacy licensed under this 105 be provided to the pharmacy within 120 days after the conclusion of the audit. chapter is conducted directly or indirectly by a managed care 106 company, an insurance company, a third-party payor, a pharmacy 107 (h) A pharmacy may To produce documentation to address a benefit manager, or an entity that represents responsible 108 discrepancy or audit finding within 10 business days after the parties such as companies or groups, referred to as an "entity" 109 preliminary audit report is delivered to the pharmacy. in this section, the pharmacy has the following rights: 110 (i) A copy of <del>To receive</del> the final audit report must be (a) The pharmacy must  $\frac{1}{10}$  be notified at least 7 calendar 111 provided to the pharmacy within 6 months after receipt of days before the initial onsite audit for each audit cycle. 112 receiving the preliminary audit report. 113 (b) An To have the onsite audit may not be scheduled during (j) Any To have recoupment or penalties must be calculated after the first 3 calendar days of a month unless the pharmacist 114 based on actual overpayments and not according to the accounting 115 practice of extrapolation. (c) The scope of To have the audit period must be limited 116 (2) The rights contained in This section does do not apply Page 3 of 18 Page 4 of 18 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

1117 118 119 120 121 122 123	597-02766-20 20201338c1 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
118 119 120 121 122	<ul> <li>(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;</li> <li>(b) Audits of claims paid for by federally funded programs; or</li> <li>(c) Concurrent reviews or desk audits that occur within 3</li> </ul>
119 120 121 122	<pre>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</pre>
120 121 122	<pre>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</pre>
121 122	<pre>investigative methods; (b) Audits of claims paid for by federally funded programs; or (c) Concurrent reviews or desk audits that occur within 3</pre>
122	<ul><li>(b) Audits of claims paid for by federally funded programs;</li><li>or</li><li>(c) Concurrent reviews or desk audits that occur within 3</li></ul>
	or (c) Concurrent reviews or desk audits that occur within 3
123	(c) Concurrent reviews or desk audits that occur within 3
124	business days after of transmission of a claim and where no
125	
126	chargeback or recoupment is demanded.
127	(3) An entity that audits a pharmacy located within a
128	Health Care Fraud Prevention and Enforcement Action Team (HEAT)
129	Task Force area designated by the United States Department of
130	Health and Human Services and the United States Department of
131	Justice may dispense with the notice requirements of paragraph
132	(1) (a) if such pharmacy has been a member of a credentialed
133	provider network for less than 12 months.
134	(4) Pursuant to s. 408.7057 and after receipt of the final
135	audit report issued by the health insurer or health maintenance
136	organization, a pharmacy may appeal the findings of the final
137	audit as to whether a claim payment is due or the amount of a
138	claim payment.
139	(5) If a health insurer or health maintenance organization
140	transfers to a pharmacy benefit manager through a contract the
141	obligation to pay any pharmacy licensed under chapter 465 for
142	any pharmacy benefit claims arising from services provided to or
143	for the benefit of any insured or subscriber, the health insurer
144	or health maintenance organization remains responsible for any
145	violations of this section, s. 627.6131, or s. 641.3155.

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146	Section 3. Section 624.492, Florida Statutes, is created to
147	read:
148	624.492 Health insurer, health maintenance organization,
149	and pharmacy benefit manager reporting requirements
150	(1) This section applies to:
151	(a) A health insurer or health maintenance organization
152	issuing, delivering, or issuing for delivery comprehensive major
153	medical individual or group insurance policies or health
154	maintenance contracts, respectively, in this state; and
155	(b) A pharmacy benefit manager providing pharmacy benefit
156	management services on behalf of a health insurer or health
157	maintenance organization described in paragraph (a) and managing
158	prescription drug coverage under a contract with the health
159	insurer or health maintenance organization.
160	(2) By March 1 annually, a health insurer or health
161	maintenance organization, or a pharmacy benefit manager on
162	behalf of a health insurer or health maintenance organization,
163	shall report, in a form and manner as prescribed by the
164	commission, the following information to the office with respect
165	to services provided by the health insurer or health maintenance
166	organization, or the pharmacy benefit manager on behalf of the
167	insurer or health maintenance organization, for the immediately
168	preceding policy or contract year:
169	(a) The total number of prescriptions that were dispensed.
170	(b) The number and percentage of all prescriptions that
171	were provided through retail pharmacies compared to mail-order
172	pharmacies. This paragraph applies to pharmacies licensed under
173	chapter 465 which dispense drugs to the general public and which
174	were paid by the health insurer, health maintenance

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175	organization, or pharmacy benefit manager under the contract.
176	(c) For retail pharmacies and mail-order pharmacies
177	described in paragraph (b), the general dispensing rate, which
178	is the number and percentage of prescriptions for which a
179	generic drug was available and dispensed.
180	(d) The aggregate amount and types of rebates, discounts,
181	price concessions, or other earned revenues that the health
182	insurer, health maintenance organization, or pharmacy benefit
183	manager negotiated for and are attributable to patient
184	utilization under the plan, excluding bona fide service fees
185	that include, but are not limited to, distribution service fees,
186	inventory management fees, product stocking allowances, and fees
187	associated with administrative services agreements and patient
188	care programs.
189	(e) If negotiated by the pharmacy benefit manager, the
190	aggregate amount of the rebates, discounts, or price concessions
191	under paragraph (d) which were passed through to the health
192	insurer or health maintenance organization.
193	(f) If the health insurer or health maintenance
194	organization contracted with a pharmacy benefit manager, the
195	aggregate amount of the difference between the amount the health
196	insurer or health maintenance organization paid the pharmacy
197	benefit manager and the amount the pharmacy benefit manager paid
198	retail pharmacies and mail order pharmacies.
199	(3) A pharmacy benefit manager that reports the information
200	under subsection (2) to the office shall also provide the
201	information to the health insurer or health maintenance
202	organization with which the pharmacy benefit manager is under
203	contract.
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204	(4) The commission may adopt rules to administer this
205	section.
206	Section 4. Section 627.64741, Florida Statutes, is amended
207	to read:
208	627.64741 Pharmacy benefit manager contracts
209	(1) As used in this section, the term:
210	(a) "Brand-name drug" means a drug that:
211	1. Is a brand drug described by Medi-Span and has a
212	multisource code field containing an $\ensuremath{``M''}$ (cobranded product), an
213	``O'' (originator brand), or an $``N''$ (single-source brand), except
214	for a drug with a multisource code of "O" and a Dispense as
215	Written code of 3, 4, 5, 6, or 9; or
216	2. Has an equivalent brand drug designation in the First
217	Databank FDB MedKnowledge database.
218	(b) "Generic drug" means a drug that:
219	1. Is a generic drug described by Medi-Span and has a
220	multisource code field containing a $``Y''$ (generic), or an $``O''$ and
221	a Dispense as Written code of 3, 4, 5, 6, or 9; or
222	2. Has an equivalent generic drug designation in the First
223	Databank FDB MedKnowledge database.
224	(c) "Maximum allowable cost" means the per-unit amount that
225	a pharmacy benefit manager reimburses a pharmacist for a
226	prescription drug:
227	1. As specified at the time of claim processing and
228	directly or indirectly reported on the initial remittance advice
229	of an adjudicated claim for a generic drug, brand-name drug,
230	biological product, or specialty drug;
231	2. Which amount must be based on pricing published in the
232	Medi-Span Master Drug Database, or, if the pharmacy benefit
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597-02766-20 20201338c1 233 manager uses only First Databank FDB MedKnowledge, must be based 234 on pricing published in First Databank FDB MedKnowledge; and 235 3.  $\tau$  Excluding dispensing fees, prior to the application of 236 copayments, coinsurance, and other cost-sharing charges, if any. (d) (b) "Pharmacy benefit manager" means a person or entity 237 238 doing business in this state which contracts to administer or 239 manage prescription drug benefits on behalf of a health insurer 240 to residents of this state. 241 (2) A health insurer may contract only with a pharmacy 242 benefit manager that A contract between a health insurer and a 243 pharmacy benefit manager must require that the pharmacy benefit 244 manager: 245 (a) Updates Update maximum allowable cost pricing 246 information at least every 7 calendar days. 247 (b) Maintains Maintain a process that will, in a timely 248 manner, eliminate drugs from maximum allowable cost lists or 249 modify drug prices to remain consistent with changes in pricing 250 data used in formulating maximum allowable cost prices and 251 product availability. 252 (c) (3) Does not limit A contract between a health insurer 253 and a pharmacy benefit manager must prohibit the pharmacy 254 benefit manager from limiting a pharmacist's ability to disclose 255 whether the cost-sharing obligation exceeds the retail price for 256 a covered prescription drug, and the availability of a more 257 affordable alternative drug, pursuant to s. 465.0244. 258 (d) (4) Does not require A contract between a health insurer 259 and a pharmacy benefit manager must prohibit the pharmacy 260 benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that 261 Page 9 of 18

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262	exceeds the lesser of:
263	1.(a) The applicable cost-sharing amount; or
264	2.(b) The retail price of the drug in the absence of
265	prescription drug coverage.
266	(3) A drug identified as a brand-name drug must be
267	considered a brand-name drug for all purposes under an
268	agreement, contract, or amendment to a contract between a
269	pharmacy benefit manager and a pharmacy, or a pharmacy services
270	administration organization on behalf of the pharmacy. A single-
271	source generic drug with only one manufacturer must be
272	reimbursed as if it were a brand-name drug.
273	(4) A drug identified as a generic drug must be considered
274	a generic drug for all purposes under an agreement, contract, or
275	amendment to a contract between a pharmacy benefit manager and a
276	pharmacy, or a pharmacy services administrative organization
277	acting on behalf of the pharmacy. The pharmacy benefit manager
278	and the pharmacy, or a pharmacy services administrative
279	organization on behalf of the pharmacy, shall agree that if the
280	pharmacy benefit manager is provided any rebate or other
281	financial benefit for any drug identified as a generic drug, the
282	pharmacy benefit manager must pass through all such rebates or
283	other financial benefits to the health insurer.
284	(5) The office may require a health insurer to submit to
285	the office any contract, or amendments to a contract, for the
286	administration or management of prescription drug benefits by a
287	pharmacy benefit manager on behalf of the insurer.
288	(6) After review of a contract under subsection (5), the
289	office may order the insurer to cancel the contract in
290	accordance with the terms of the contract and applicable law $\operatorname{if}$
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291	the office determines that any of the following conditions
292	exist:
293	(a) The fees to be paid by the insurer are so unreasonably
294	high as compared with similar contracts entered into by
295	insurers, or as compared with similar contracts entered into by
296	other insurers in similar circumstances, that the contract is
297	detrimental to the policyholders of the insurer.
298	(b) The contract does not comply with the Florida Insurance
299	Code.
300	(c) The pharmacy benefit manager is not registered with the
301	office pursuant to s. 624.490.
302	(7) The commission may adopt rules to administer this
303	section.
304	(8) (5) This section applies to contracts entered into,
305	amended, or renewed on or after July 1, 2020 2018.
306	Section 5. Section 627.6572, Florida Statutes, is amended
307	to read:
308	627.6572 Pharmacy benefit manager contracts
309	(1) As used in this section, the term:
310	(a) "Brand-name drug" means a drug that:
311	1. Is a brand drug described by Medi-Span and has a
312	multisource code field containing an $\ensuremath{``\!M''}$ (cobranded product), an
313	$\underline{\ \ } 0''$ (originator brand), or an $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$
314	for a drug with a multisource code of "O" and a Dispense as
315	Written code of 3, 4, 5, 6, or 9; or
316	2. Has an equivalent brand drug designation in the First
317	Databank FDB MedKnowledge database.
318	(b) "Generic drug" means a drug that:
319	1. Is a generic drug described by Medi-Span and has a
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320	multisource code field containing a $``Y''$ (generic), or an $``O''$ and	
321	a Dispense as Written code of 3, 4, 5, 6, or 9; or	
322	2. Has an equivalent generic drug designation in the First	
323	Databank FDB MedKnowledge database.	
324	(c) "Maximum allowable cost" means the per-unit amount that	
325	a pharmacy benefit manager reimburses a pharmacist for a	
326	prescription drug:	
327	1. As specified at the time of claim processing and	
328	directly or indirectly reported on the initial remittance advice	
329	of an adjudicated claim for a generic drug, brand-name drug,	
330	biological product, or specialty drug;	
331	2. Which amount must be based on pricing published in the	
332	Medi-Span Master Drug Database, or, if the pharmacy benefit	
333	manager uses only First Databank FDB MedKnowledge, must be based	
334	on pricing published in First Databank FDB MedKnowledge; and	
335	$\underline{3.}$ 7 Excluding dispensing fees, prior to the application of	
336	copayments, coinsurance, and other cost-sharing charges, if any.	
337	(d) (b) "Pharmacy benefit manager" means a person or entity	
338	doing business in this state which contracts to administer or	
339	manage prescription drug benefits on behalf of a health insurer	
340	to residents of this state.	
341	(2) A health insurer may contract only with a pharmacy	
342	benefit manager that A contract between a health insurer and a	
343	pharmacy benefit manager must require that the pharmacy benefit	
344	manager:	
345	(a) <u>Updates</u> <del>Update</del> maximum allowable cost pricing	
346	information at least every 7 calendar days.	
347	(b) <u>Maintains</u> Maintain a process that will, in a timely	
348	manner, eliminate drugs from maximum allowable cost lists or	
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1	597-02766-20 20201338c
349	modify drug prices to remain consistent with changes in pricing
350	data used in formulating maximum allowable cost prices and
351	product availability.
352	(c) (3) Does not limit A contract between a health insurer
353	and a pharmacy benefit manager must prohibit the pharmacy
354	benefit manager from limiting a pharmacist's ability to disclose
355	whether the cost-sharing obligation exceeds the retail price for
356	a covered prescription drug, and the availability of a more
357	affordable alternative drug, pursuant to s. 465.0244.
358	(d) (4) Does not require A contract between a health insurer
359	and a pharmacy benefit manager must prohibit the pharmacy
360	benefit manager from requiring an insured to make a payment for
361	a prescription drug at the point of sale in an amount that
362	exceeds the lesser of:
363	<u>1.(a)</u> The applicable cost-sharing amount; or
364	2.(b) The retail price of the drug in the absence of
365	prescription drug coverage.
366	(3) A drug identified as a brand-name drug must be
367	considered a brand-name drug for all purposes under an
368	agreement, contract, or amendment to a contract between a
369	pharmacy benefit manager and pharmacy, or a pharmacy services
370	administration organization on behalf of the pharmacy. A single-
371	source generic drug with only one manufacturer must be
372	reimbursed as if it were a brand-name drug.
373	(4) A drug identified as a generic drug must be considered
374	a generic drug for all purposes under an agreement, contract, or
375	amendment to a contract between a pharmacy benefit manager and a
376	pharmacy, or a pharmacy services administrative organization
377	acting on behalf of the pharmacy. The pharmacy benefit manager
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378	and the pharmacy, or a pharmacy services administrative
379	organization on behalf of the pharmacy, shall agree that if the
380	pharmacy benefit manager is provided any rebate or other
381	financial benefit for any drug identified as a generic drug, the
382	pharmacy benefit manager must pass through all such rebates or
383	other financial benefits to the health insurer.
384	(5) The office may require a health insurer to submit to
385	the office any contract, or amendments to a contract, for the
386	administration or management of prescription drug benefits by a
387	pharmacy benefit manager on behalf of the insurer.
388	(6) After review of a contract under subsection (5), the
389	office may order the insurer to cancel the contract in
390	accordance with the terms of the contract and applicable law if
391	the office determines that any of the following conditions
392	exist:
393	(a) The fees to be paid by the insurer are so unreasonably
394	high as compared with similar contracts entered into by
395	insurers, or as compared with similar contracts entered into by
396	other insurers in similar circumstances, that the contract is
397	detrimental to the policyholders of the insurer.
398	(b) The contract does not comply with the Florida Insurance
399	Code.
400	(c) The pharmacy benefit manager is not registered with the
401	office pursuant to s. 624.490.
402	(7) The commission may adopt rules to administer this
403	section.
404	(8) (5) This section applies to contracts entered into $\underline{(8)}$
405	amended, or renewed on or after July 1, 2020 2018.
406	Section 6. Section 641.314, Florida Statutes, is amended to
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407	read:		43	
408	641.314 Pharmacy benefit manager contracts		43	
409	(1) As used in this section, the term:		43	
410	(a) "Brand-name drug" means a drug that:		43	manage prescription drug benefits on behalf of a health
411	1. Is a brand drug described by Medi-Span and has a		44	maintenance organization to residents of this state.
412	multisource code field containing an "M" (cobranded product), an		44	(2) A health maintenance organization may contract only
413	"O" (originator brand), or an "N" (single-source brand), except		44	12 with a pharmacy benefit manager that A contract between a health
414	for a drug with a multisource code of "O" and a Dispense as		44	13 maintenance organization and a pharmacy benefit manager must
415	Written code of 3, 4, 5, 6, or 9; or		44	14 require that the pharmacy benefit manager:
416	2. Has an equivalent brand drug designation in the First		44	(a) Updates <del>Update</del> maximum allowable cost pricing
417	Databank FDB MedKnowledge database.		44	16 information at least every 7 calendar days.
418	(b) "Generic drug" means a drug that:		44	(b) <u>Maintains</u> Maintain a process that will, in a timely
419	1. Is a generic drug described by Medi-Span and has a		44	18 manner, eliminate drugs from maximum allowable cost lists or
420	multisource code field containing a "Y" (generic), or an "O" and		44	9 modify drug prices to remain consistent with changes in pricing
421	a Dispense as Written code of 3, 4, 5, 6, or 9; or		45	data used in formulating maximum allowable cost prices and
422	2. Has an equivalent generic drug designation in the First		45	j1 product availability.
423	Databank FDB MedKnowledge database.		45	2 (c) (3) Does not limit A contract between a health
424	(c) "Maximum allowable cost" means the per-unit amount that		45	3 maintenance organization and a pharmacy benefit manager must
425	a pharmacy benefit manager reimburses a pharmacist for a		45	prohibit the pharmacy benefit manager from limiting a
426	prescription drug:		45	5 pharmacist's ability to disclose whether the cost-sharing
427	1. As specified at the time of claim processing and		45	obligation exceeds the retail price for a covered prescription
428	directly or indirectly reported on the initial remittance advice		45	drug, and the availability of a more affordable alternative
429	of an adjudicated claim for a generic drug, brand-name drug,		45	drug, pursuant to s. 465.0244.
430	biological product, or specialty drug;		45	(d) (4) Does not require A contract between a health
431	2. Which amount must be based on pricing published in the		46	maintenance organization and a pharmacy benefit manager must
432	Medi-Span Master Drug Database, or, if the pharmacy benefit		46	prohibit the pharmacy benefit manager from requiring a
433	manager uses only First Databank FDB MedKnowledge, must be based		46	52 subscriber to make a payment for a prescription drug at the
434	on pricing published in First Databank FDB MedKnowledge; and		46	point of sale in an amount that exceeds the lesser of:
435	$\underline{3.}$ $_{ au}$ Excluding dispensing fees, prior to the application of		46	1. (a) The applicable cost-sharing amount; or
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465	2. <del>(b)</del> The retail price of the drug in the absence of
466	prescription drug coverage.
467	(3) A drug identified as a brand-name drug must be
468	considered a brand-name drug for all purposes under an
469	agreement, contract, or amendment to a contract between a
470	pharmacy benefit manager and a pharmacy, or a pharmacy services
471	administration organization on behalf of the pharmacy. A single-
472	source generic drug with only one manufacturer must be
473	reimbursed as if it were a brand-name drug.
474	(4) A drug identified as a generic drug must be considered
475	a generic drug for all purposes under an agreement, contract, or
476	amendment to a contract between a pharmacy benefit manager and a
477	pharmacy, or a pharmacy services administrative organization
478	acting on behalf of the pharmacy. The pharmacy benefit manager
479	and the pharmacy, or a pharmacy services administrative
480	organization on behalf of the pharmacy, shall agree that if the
481	pharmacy benefit manager is provided any rebate or other
482	financial benefit for any drug identified as a generic drug, the
483	pharmacy benefit manager must pass through all such rebates or
484	other financial benefits to the health maintenance organization.
485	(5) The office may require a health maintenance
486	organization to submit to the office any contract, or amendments
487	to a contract, for the administration or management of
488	prescription drug benefits by a pharmacy benefit manager on
489	behalf of the health maintenance organization.
490	(6) After review of a contract under subsection (5), the
491	office may order the health maintenance organization to cancel
492	the contract in accordance with the terms of the contract and
493	applicable law if the office determines that any of the
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494	following conditions exist:
495	(a) The fees to be paid by the health maintenance
496	organization are so unreasonably high as compared with similar
497	contracts entered into by health maintenance organizations, or
498	as compared with similar contracts entered into by other health
499	maintenance organizations in similar circumstances, that the
500	contract is detrimental to the subscribers of the health
501	maintenance organization.
502	(b) The contract does not comply with the Florida Insurance
503	Code.
504	(c) The pharmacy benefit manager is not registered with the
505	office pursuant to s. 624.490.
506	(7) The commission may adopt rules to administer this
507	section.
508	(8) (5) This section applies to pharmacy benefit manager
509	contracts entered into, amended, or renewed on or after July 1,
510	<u>2020</u> <del>2018</del> .
511	Section 7. This act shall take effect July 1, 2020.
ļ	
	Page 18 of 18

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

LEGISLATIVE ACTION

Senate Comm: RCS 02/25/2020 House

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.

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(b) "Pharmacy benefit manager" means a person or entity

COMMITTEE AMENDMENT

Florida Senate - 2020 Bill No. CS for SB 1338

636790

11 doing business in this state which contracts to administer or 12 manage prescription drug benefits on behalf of a health insurer 13 to residents of this state.

(2) <u>A health insurer may contract only with a pharmacy</u> <u>benefit manager that</u> A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) <u>Updates</u> <del>Update</del> maximum allowable cost pricing information at least every 7 calendar days.

(b) <u>Maintains</u> <u>Maintain</u> 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:

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1.(a) The applicable cost-sharing amount; or

 $\frac{2.(b)}{b}$  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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40	the office any contract, or amendments to a contract, for the
41	administration or management of prescription drug benefits by a
42	pharmacy benefit manager on behalf of the insurer.
43	(4) After review of a contract under subsection (3), the
44	office may order the insurer to cancel the contract in
45	accordance with the terms of the contract and applicable law if
46	the office determines that any of the following conditions
47	<u>exist:</u>
48	(a) The fees to be paid by the insurer are so unreasonably
49	high as compared with similar contracts entered into by
50	insurers, or as compared with similar contracts entered into by
51	other insurers in similar circumstances, that the contract is
52	detrimental to the policyholders of the insurer.
53	(b) The contract does not comply with the Florida Insurance
54	Code.
55	(c) The pharmacy benefit manager is not registered with the
56	office pursuant to s. 624.490.
57	(5) The commission may adopt rules to administer this
58	section.
59	<u>(6)</u> This section applies to contracts entered into <u>,</u>
60	amended, or renewed on or after July 1, 2020 2018.
61	Section 5. Section 627.6572, Florida Statutes, is amended
62	to read:
63	627.6572 Pharmacy benefit manager contracts
64	(1) As used in this section, the term:
65	(a) "Maximum allowable cost" means the per-unit amount that
66	a pharmacy benefit manager reimburses a pharmacist for a
67	prescription drug, excluding dispensing fees, prior to the
68	application of copayments, coinsurance, and other cost-sharing

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69 charges, if any.

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(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) <u>A health insurer may contract only with a pharmacy</u> <u>benefit manager that</u> <u>A contract between a health insurer and a</u> <u>pharmacy benefit manager must require that the pharmacy benefit</u> <u>manager</u>:

(a) <u>Updates</u> <del>Update</del> maximum allowable cost pricing information at least every 7 calendar days.

(b) <u>Maintains</u> <u>Maintain</u> 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:

96 97 1.(a) The applicable cost-sharing amount; or 2.(b) The retail price of the drug in the absence of

COMMITTEE AMENDMENT

Florida Senate - 2020 Bill No. CS for SB 1338

# 636790

98	prescription drug coverage.
99	(3) The office may require a health insurer to submit to
100	the office any contract, or amendments to a contract, for the
101	administration or management of prescription drug benefits by a
102	pharmacy benefit manager on behalf of the insurer.
103	(4) After review of a contract under subsection (3), the
104	office may order the insurer to cancel the contract in
105	accordance with the terms of the contract and applicable law if
106	the office determines that any of the following conditions
107	exist:
108	(a) The fees to be paid by the insurer are so unreasonably
109	high as compared with similar contracts entered into by
110	insurers, or as compared with similar contracts entered into by
111	other insurers in similar circumstances, that the contract is
112	detrimental to the policyholders of the insurer.
113	(b) The contract does not comply with the Florida Insurance
114	Code.
115	(c) The pharmacy benefit manager is not registered with the
116	office pursuant to s. 624.490.
117	(5) The commission may adopt rules to administer this
118	section.
119	(6)(5) This section applies to contracts entered into,
120	amended, or renewed on or after July 1, 2020 2018.
121	Section 6. Section 641.314, Florida Statutes, is amended to
122	read:
123	641.314 Pharmacy benefit manager contracts
124	(1) As used in this section, the term:
125	(a) "Maximum allowable cost" means the per-unit amount that
126	a pharmacy benefit manager reimburses a pharmacist for a

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127 prescription drug, excluding dispensing fees, prior to the 128 application of copayments, coinsurance, and other cost-sharing 129 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) <u>A health maintenance organization may contract only</u> with a pharmacy benefit manager that <u>A contract between a health</u> maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) <u>Updates</u> <del>Update</del> maximum allowable cost pricing information at least every 7 calendar days.

(b) <u>Maintains</u> <u>Maintain</u> 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.

152 <u>(d) (4)</u> Does not require A contract between a health 153 maintenance organization and a pharmacy benefit manager must 154 prohibit the pharmacy benefit manager from requiring a 155 subscriber to make a payment for a prescription drug at the

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156	point of sale in an amount that exceeds the lesser of:
157	<u>1.(a)</u> The applicable cost-sharing amount; or
158	<u>2.(b)</u> The retail price of the drug in the absence of
159	prescription drug coverage.
160	(3) The office may require a health maintenance
161	organization to submit to the office any contract, or amendments
162	to a contract, for the administration or management of
163	prescription drug benefits by a pharmacy benefit manager on
164	behalf of the health maintenance organization.
165	(4) After review of a contract under subsection (3), the
166	office may order the health maintenance organization to cancel
167	the contract in accordance with the terms of the contract and
168	applicable law if the office determines that any of the
169	following conditions exist:
170	(a) The fees to be paid by the health maintenance
171	organization are so unreasonably high as compared with similar
172	contracts entered into by health maintenance organizations, or
173	as compared with similar contracts entered into by other health
174	maintenance organizations in similar circumstances, that the
175	contract is detrimental to the subscribers of the health
176	maintenance organization.
177	(b) The contract does not comply with the Florida Insurance
178	Code.
179	(c) The pharmacy benefit manager is not registered with the
180	office pursuant to s. 624.490.
181	(5) The commission may adopt rules to administer this
182	section.
183	(6)(5) This section applies to pharmacy benefit manager
184	



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.)

Prepareo	d By: The Prof	essional Sta	aff of the Appro	priations Subcommi	ttee on Health	and Human Services
BILL:	CS/SB 154	4				
INTRODUCER:	Health Policy Committee and Senator Albritton					
SUBJECT:	Long-term	Care				
DATE:	February 2	4, 2020	REVISED:			
ANAL	YST	STAFF	DIRECTOR	REFERENCE		ACTION
. Looke		Brown		HP	Fav/CS	
2. McKnight		Kidd		AHS	Recomme	nd: 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.

val 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

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* <a href="http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Signed_appro">http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Signed_appro</a>

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 Le tter_2016-12-19.pdf (last visited Feb. 19, 2020).

⁷ Medicaid.gov, *Nursing Facilities, available at* <u>https://www.medicaid.gov/medicaid/long-term-services-</u> 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* <u>http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml</u> (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* <u>https://aspe.hhs.gov/poverty-guidelines</u> (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* <u>https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets.html</u> (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 <u>https://ahca.myflorida.com/medicaid/stateplan_attach.shtml</u> (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 <a href="http://elderaffairs.state.fl.us/doea/cares.php">http://elderaffairs.state.fl.us/doea/cares.php</a> (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 <u>http://elderaffairs.state.fl.us/doea/sops.php</u> (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.

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



The Florida Senate

# **Committee Agenda Request**

То:	Senator Aaron Bean, Chair Appropriations Subcommittee on Health and Human Services
Subject:	Committee Agenda Request

**Date:** February 10, 2020

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.

Alla

Senator Ben Albritton Florida Senate, District 26

THE FLORIDA SENATE	
APPEARANCE RECO	RD
$\frac{2 - 25 - 20}{Meeting Date}$ (Deliver BOTH copies of this form to the Senator or Senate Professional S	Staff conducting the meeting) <u>5B 1544</u> Bill Number (if applicable)
Topic Long Term Care	Amendment Barcode (if applicable)
Name Dorche Barker	
Job Title Associate State Director	~
Address 215 S. Monroe St., Suite 603	Phone \$50-228-6387
City State Zip	Email dobarker Caarp.org
	peaking: In Support Against air will read this information into the record.)
Representing <u>AARP</u> FL	
Appearing at request of Chair: Yes No Lobbyist regist	tered with Legislature: Ves 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 RECO	RD
$\frac{2125}{20}$ (Deliver BOTH copies of this form to the Senator or Senate Professional S Meeting Date	itaff conducting the meeting) <i>1544</i> <i>Bill Number (if applicable)</i>
Topic Long Term Care	Amendment Barcode (if applicable)
Name Robert Beck	4
Job Title PinPoint Results	
Address 150 S. Monroe Suite 303 Street	Phone 850 766 1410
	Email Kobot Sin Printresults-com
	peaking: In Support Against ir will read this information into the record.)
Representing FloridA's ARea Agencies on A	jing
Appearing at request of Chair: Yes No Lobbyist regist	ered 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 RECO	RD
(Deliver BOTH copies of this form to the Senator or Senate Professional St Meeting Date	taff conducting the meeting) $\frac{1544}{Bill Number (if applicable)}$
Topic Long-Term Care	Amendment Barcode (if applicable)
Name Tanya C. Jackson	
Job Title	
Address 150 S. Monroe St., Ste. 303 Street Talbhasseg FL 32201	Phone <u>850-445-0107</u> Email Tana PinPointResults, com
City     State     Zip       Speaking:     For     Against     Information     Waive Speaking	peaking: In Support Against ir will read this information into the record.)
Representing 1199 SEIU Healthcare Workers	
Appearing at request of Chair: Yes Xo Lobbyist regist	ered with Legislature: Yes 🗌 No
	I

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)

CS for SB 1544

By the Committee on Health Policy; and Senator Albritton

588-03089-20 588-03089-20 20201544c1 20201544c1 1 A bill to be entitled 30 individuals for potential enrollment for home and community-2 An act relating to long-term care; amending s. 31 based services through the long-term care managed care program 409.979, F.S.; requiring aging resource center 32 using a frailty-based screening tool that results in a priority 3 personnel to annually rescreen certain individuals 33 score. The priority score is used to set an order for releasing with high priority scores for purposes of the 34 individuals from the wait list for potential enrollment in the statewide wait list for enrollment for home and 35 long-term care managed care program. If capacity is limited for community-based services; authorizing such personnel 36 individuals with identical priority scores, the individual with to administer rescreening for certain individuals with 37 the oldest date of placement on the wait list shall receive 8 ç low priority scores; requiring the Department of 38 priority for release. 10 Elderly Affairs to maintain contact information for 39 1. Pursuant to s. 430.2053, aging resource center personnel 11 individuals with low priority scores for rescreening 40 certified by the Department of Elderly Affairs shall perform the 12 screening for each individual requesting enrollment for home and purposes; requiring aging resource center personnel to 41 13 inform such individuals of community resources; community-based services through the long-term care managed care 42 14 amending s. 430.205, F.S.; authorizing community-care-43 program. The Department of Elderly Affairs shall request that 15 for-the-elderly services providers to dispute certain 44 the individual or the individual's authorized representative 16 provide alternate contact names and contact information. referrals; providing that a referral decision by adult 45 17 protective service prevails; providing an effective 2. The individual requesting the long-term care services, 46 18 or the individual's authorized representative, must participate date. 47 19 48 in an initial screening or rescreening for placement on the wait 20 Be It Enacted by the Legislature of the State of Florida: 49 list. The screening or rescreening must be completed in its 21 entirety before placement on the wait list. 50 22 Section 1. Paragraphs (a) and (b) of subsection (3) of 51 3. Pursuant to s. 430.2053, aging resource center personnel 23 section 409.979, Florida Statutes, are amended to read: 52 shall administer rescreening annually or upon notification of a 24 409.979 Eligibility.-53 significant change in an individual's circumstances for an 25 individual with a high priority score. Aging resource center (3) WAIT LIST, RELEASE, AND OFFER PROCESS.-The Department 54 26 of Elderly Affairs shall maintain a statewide wait list for 55 personnel may administer rescreening annually or upon 27 enrollment for home and community-based services through the 56 notification of a significant change in an individual's 2.8 long-term care managed care program. 57 circumstances for an individual with a low priority score. 29 (a) The Department of Elderly Affairs shall prioritize 58 4. The Department of Elderly Affairs shall adopt by rule a Page 1 of 4 Page 2 of 4 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

20201544c1 588-03089-20 59 screening tool that generates the priority score, and shall make 60 publicly available on its website the specific methodology used 61 to calculate an individual's priority score. 62 (b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the 63 individual or the individual's authorized representative that 64 65 the individual has been placed on the wait list, unless the 66 individual has a low priority score. The Department of Elderly 67 Affairs must maintain contact information for each individual 68 with a low priority score for purposes of any future 69 rescreening. Aging resource center personnel shall inform 70 individuals with low priority scores of community resources available to assist them and inform them that they may contact 71 72 the aging resource center for a new assessment at any time if 73 they experience a change in circumstances. 74 Section 2. Paragraph (a) of subsection (5) of section 75 430.205, Florida Statutes, is amended to read: 76 430.205 Community care service system.-77 (5) Any person who has been classified as a functionally 78 impaired elderly person is eligible to receive community-care-79 for-the-elderly core services. 80 (a) Those elderly persons who are determined by protective 81 investigations to be vulnerable adults in need of services, 82 pursuant to s. 415.104(3)(b), or to be victims of abuse, 83 neglect, or exploitation who are in need of immediate services 84 to prevent further harm and are referred by the adult protective 85 services program, shall be given primary consideration for 86 receiving community-care-for-the-elderly services. As used in this paragraph, "primary consideration" means that an assessment 87 Page 3 of 4

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

588-03089-20 20201544c1 88 and services must commence within 72 hours after referral to the 89 department or as established in accordance with department 90 contracts by local protocols developed between department 91 service providers and the adult protective services program. 92 Regardless, a community-care-for-the-elderly services provider may dispute a referral under this paragraph by requesting that 93 94 adult protective services negotiate the referral placement of, 95 and the services to be provided to, a vulnerable adult or victim of abuse, neglect, or exploitation. If an agreement cannot be 96 reached with adult protective services for modification of the 97 98 referral decision, the determination by adult protective 99 services shall prevail. 100 Section 3. This act shall take effect July 1, 2020.

Page 4 of 4 CODING: Words stricken are deletions; words <u>underlined</u> are additions.

# The Florida Senate BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services								
BILL:	PCS/CS/SB 1726 (233364)							
INTRODUCER:	R: Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Bean							
SUBJECT:	Agency for Health Care Administration							
DATE:	February 2	6, 2020	REVISED:		·			
ANALYST		STAFF	DIRECTOR	REFERENCE		ACTION		
l. Kibbey		Brown		HP	Fav/CS			
. McKnight K		Kidd	Kidd AHS		<b>Recommend: Fav/CS</b>			
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 <u>http://ahca.myflorida.com/MCHQ/index.shtml</u> (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

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* <u>https://www.flsenate.gov/Session/Bill/2019/21/Analyses/h0021z1.HMR.PDF</u> (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

¹⁶ Id.

¹⁷ Id.

 18  Id.

¹⁹ Id. ²⁰ Id.

¹⁵ 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.

²⁵ Id.

²⁶ *Id*.

²⁷ Id.

²¹ Chapter No. 2019-116, s. 38, Laws of Fla.

²² Id.

²³ Supra note 10.

 $^{^{24}}$  *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 <u>http://laws.flrules.org/files/Ch_2001-104.pdf</u> (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* <u>http://www.flsenate.gov/Session/Bill/2001/792/Analyses/20010792SHC_2001s0792.hc.pdf</u> (last visited Jan. 30, 2020).

³⁶ See the Office of Medicaid Program Integrity's web page at <u>https://ahca.myflorida.com/MCHQ/MPI/</u> (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 diseases³⁹ (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

⁴⁰ Supra note 5.

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.

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.

⁴⁸ Id.

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.

**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 Statute⁵⁶ prohibits the knowing

⁵¹ *Id*.

 55  Id.

⁵⁶ 42 U.S.C. s. 1320a-7b(b).

⁴⁹ Supra note 10.

 $^{^{50}}$  *Id*.

⁵² *Id.* 

⁵³ Id. ⁵⁴ Id.

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 <u>www.FloridaHealthFinder.gov</u>, which was established by law in 2016⁶⁰, 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 Act⁶¹ (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.

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

THE FLORIDA SENAT	E
APPEARANCE RE	CORD
Z-Z5-20       (Deliver BOTH copies of this form to the Senator or Senate Profesting Date         Meeting Date       (Deliver BOTH copies of this form to the Senator or Senate Profesting Date)	ssional Staff conducting the meeting) B 1726 Bill Number (if applicable)
Topic Agency for HEAlth CARE Name Dr. Steve Coleman	Amendment Barcode (if applicable)
Name Dr. Steve ColeMAN	
Job Title Public Policy Director	
Address 3116 CAPITAL CIT. NE.	Phone 904-635-7155
TALAHASSEE FL 3230 City State Zip	8 Email Fleve ColEMAN OFAbAWORK,
	aive Speaking: In Support Against // Against
Representing Florida ASSociation For B	shavios ANDLYSis
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 APPEARANC 26 (Deliver BOTH copies of this form to the Senator or Se	E RECO	
Meeting Date		Bill Number (if applicable)
Topic hang term Care/AttCA		Amendment Barcode (if applicable)
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Job Title VP - government Relati	ion	
Address 5200 NE 2nd Ave		Phone 954-465-7431
Name <u>VP</u> - government Relati Job Title <u>VP</u> - government Relati Address <u>Street</u> MLAM Pl.	33137	Email Ebaver Eman Jewishhear th. 05
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Representing MIAMI Jewish	Healt	ty
Appearing at request of Chair: Yes 🔀 No Lo	obbyist regist	ered 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 1 A bill to be entitled 2 An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring 3 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 ç s. 395.003, F.S.; removing a requirement that 10 specified information be listed on licenses for 11 certain facilities; repealing s. 395.7015, F.S., 12 relating to an annual assessment on health care 13 entities; amending s. 395.7016, F.S.; conforming a 14 provision to changes made by the act; amending s. 15 400.19, F.S.; revising provisions requiring the agency 16 to conduct licensure inspections of nursing homes; 17 requiring the agency to conduct additional licensure 18 surveys under certain circumstances; requiring the 19 agency to assess a specified fine for such surveys; 20 amending s. 400.462, F.S.; revising definitions; 21 amending s. 400.464, F.S.; revising licensure 22 requirements for home health agencies; amending s. 23 400.471, F.S.; revising provisions related to certain 24 application requirements for home health agencies; 25 amending s. 400.492, F.S.; revising provisions related 26 to services provided by home health agencies during an 27 emergency; amending s. 400.506, F.S.; revising 28 provisions related to licensure requirements for nurse 29 registries; amending s. 400.509, F.S.; revising Page 1 of 81 CODING: Words stricken are deletions; words underlined are additions.

#### 588-02756-20 20201726c1 30 provisions related to the registration of certain 31 service providers; amending s. 400.605, F.S.; removing 32 a requirement that the agency conduct specified 33 inspections of certain licensees; amending s. 34 400.60501, F.S.; deleting an obsolete date; removing a 35 requirement that the agency develop a specified annual 36 report; amending s. 400.9905, F.S.; revising the 37 definition of the term "clinic"; amending s. 400.991, 38 F.S.; removing the option for health care clinics to 39 file a surety bond under certain circumstances; 40 amending s. 400.9935, F.S.; removing a requirement 41 that certain directors conduct specified reviews; requiring certain clinics to publish and post a 42 43 schedule of charges; amending s. 408.033, F.S.; 44 conforming a provision to changes made by the act; 45 amending s. 408.061, F.S.; revising provisions 46 requiring health care facilities to submit specified 47 data to the agency; amending s. 408.0611, F.S.; 48 removing the requirement that the agency annually 49 report to the Governor and the Legislature by a 50 specified date on the progress of implementation of 51 electronic prescribing; amending s. 408.062, F.S.; 52 removing requirements that the agency annually report 53 specified information to the Governor and Legislature 54 by a specified date and, instead, requiring the agency 55 to annually publish such information on its website; 56 amending s. 408.063, F.S.; removing a requirement that 57 the agency publish certain annual reports; amending s. 58 408.803, F.S.; conforming a definition to changes made Page 2 of 81

 $\textbf{CODING: Words } \textbf{stricken} \text{ are deletions; words } \underline{underlined} \text{ are additions.}$ 

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59	by the act; defining the term "low-risk provider";
60	amending ss. 408.802, 408.820, 408.831, and 408.832,
61	-
62	F.S.; conforming provisions to changes made by the
62 63	act; amending s. 408.806, F.S.; exempting certain
	providers from a specified inspection; amending s.
64	408.808, F.S.; authorizing the issuance of a
65	provisional license to certain applicants; amending
66	ss. 408.809 and 409.907, F.S.; revising background
67	screening requirements for certain licensees and
68	providers; amending s. 408.811, F.S.; authorizing the
69	agency to grant certain providers an exemption from a
70	specified inspection under certain circumstances;
71	authorizing the agency to adopt rules to grant waivers
72	of certain inspections and extended inspection periods
73	under certain circumstances; amending s. 408.821,
74	F.S.; revising provisions requiring licensees to have
75	a specified plan; providing requirements for the
76	submission of such plan; amending s. 408.909, F.S.;
77	removing a requirement that the agency and Office of
78	Insurance Regulation evaluate a specified program;
79	amending s. 408.9091, F.S.; requiring the agency and
80	office to each, instead of jointly, submit a specified
81	annual report to the Governor and Legislature;
82	amending s. 409.905, F.S.; providing construction for
83	a provision that requires the agency to discontinue
84	its hospital retrospective review program under
85	certain circumstances; providing legislative intent;
86	amending s. 409.913, F.S.; revising the due date for a
87	certain annual report; deleting the requirement that
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I	588-02756-20 20201726c1
88	certain agencies submit their annual reports jointly;
89	amending s. 409.967, F.S.; revising the length of
90	managed care plan contracts procured by the agency
91	beginning during a specified timeframe; requiring the
92	agency to extend the term of certain existing managed
93	care plan contracts until a specified date; amending
94	s. 429.11, F.S.; removing an authorization for the
95	issuance of a provisional license to certain
96	facilities; amending s. 429.19, F.S.; removing
97	requirements that the agency develop and disseminate a
98	specified list and the Department of Children and
99	Families disseminate such list to certain providers;
100	amending ss. 429.35, 429.905, and 429.929, F.S.;
101	revising provisions requiring a biennial inspection
102	cycle for specified facilities and centers,
103	respectively; repealing part I of ch. 483, F.S.,
104	relating to the Florida Multiphasic Health Testing
105	Center Law; redesignating parts II and III of ch. 483,
106	F.S., as parts I and II, respectively; amending ss.
107	20.43, 381.0034, 456.001, 456.057, 456.076, and
108	456.47, F.S.; conforming cross-references; providing
109	effective dates.
110	
111	Be It Enacted by the Legislature of the State of Florida:
112	
113	Section 1. Subsections (2) and (4) of section 383.327,
114	Florida Statutes, are amended to read:
115	383.327 Birth and death records; reports
116	(2) Each maternal death, newborn death, and stillbirth
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20201726c1 588-02756-20 20201726c1 146 the Public Medical Assistance Trust Fund under s.  $395.701_{\tau}$  as 147 state match for the state's Medicaid program. 148 Section 5. Subsection (3) of section 400.19, Florida 149 Statutes, is amended to read: 150 400.19 Right of entry and inspection .-151 (3) The agency shall conduct periodic, every 15 months 152 conduct at least one unannounced licensure inspections 153 inspection to determine compliance by the licensee with 154 statutes, and with rules adopted promulgated under the 155 provisions of those statutes, governing minimum standards of 156 construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the 157 next 2 year period If the facility has been cited for a class I 158 159 deficiency or  $_{\mathcal{T}}$  has been cited for two or more class II 160 deficiencies arising from separate surveys or investigations 161 within a 60-day period, the agency shall conduct an additional 162 licensure survey or has had three or more substantiated 163 complaints within a 6-month period, each resulting in at least 164 one class I or class II deficiency. In addition to any other 165 fees or fines in this part, the agency shall assess a fine for each facility that is subject to the additional licensure survey 166 6-month survey cycle. The fine for the additional licensure 167 168 survey is \$3,000 2-year period shall be \$6,000, one-half to be 169 paid at the completion of each survey. The agency may adjust 170 such this fine by the change in the Consumer Price Index, based 171 on the 12 months immediately preceding the increase, to cover 172 the cost of the additional surveys. The agency shall verify 173 through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify 174 Page 6 of 81 CODING: Words stricken are deletions; words underlined are additions.

588-02756-20 117 shall be reported immediately to the medical examiner and the 118 agency. 119 (4) A report shall be submitted annually to the agency. The 120 contents of the report and the frequency with which it is 121 submitted shall be prescribed by rule of the agency. 122 Section 2. Subsection (4) of section 395.003, Florida 123 Statutes, is amended to read: 124 395.003 Licensure; denial, suspension, and revocation.-125 (4) The agency shall issue a license that which specifies 126 the service categories and the number of hospital beds in each 127 bed category for which a license is received. Such information 128 shall be listed on the face of the license. All beds which are 129 not covered by any specialty-bed-need methodology shall be 130 specified as general beds. A licensed facility shall not operate 131 a number of hospital beds greater than the number indicated by 132 the agency on the face of the license without approval from the 133 agency under conditions established by rule. 134 Section 3. Section 395.7015, Florida Statutes, is repealed. 135 Section 4. Section 395.7016, Florida Statutes, is amended 136 to read: 137 395.7016 Annual appropriation.-The Legislature shall 138 appropriate each fiscal year from either the General Revenue 139 Fund or the Agency for Health Care Administration Tobacco 140 Settlement Trust Fund an amount sufficient to replace the funds 141 lost due to reduction by chapter 2000-256, Laws of Florida, of 142 the assessment on other health care entities under s. 395.7015, 143 and the reduction by chapter 2000-256, Laws of Florida, in the 144 assessment on hospitals under s.  $395.701_{\overline{r}}$  and to maintain 145 federal approval of the reduced amount of funds deposited into Page 5 of 81 CODING: Words stricken are deletions; words underlined are additions.

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175	the correction of a class III or class IV deficiency unrelated		204	licensed professional who has received advanced training and
176	to resident rights or resident care without reinspecting the		205	experience in intravenous infusion therapy and who administers
177	facility if adequate written documentation has been received		206	infusion therapy to a patient in the patient's home or place of
178	from the facility, which provides assurance that the deficiency		207	residence.
179	has been corrected. The giving or causing to be given of advance		208	(21) "Nurse registry" means any person or entity that
180	notice of such unannounced inspections by an employee of the		209	procures, offers, promises, or attempts to secure health-care-
181	agency to any unauthorized person shall constitute cause for		210	related contracts for registered nurses, licensed practical
182	suspension of not fewer than 5 working days according to <del>the</del>		211	nurses, certified nursing assistants, home health aides,
183	<del>provisions of</del> chapter 110.		212	companions, or homemakers, who are compensated by fees as
184	Section 6. Subsections (12), (14), (17), (21), and (22) of		213	independent contractors, including, but not limited to,
185	section 400.462, Florida Statutes, are amended to read:		214	contracts for the provision of services to patients and
186	400.462 DefinitionsAs used in this part, the term:		215	contracts to provide private duty or staffing services to health
187	(12) "Home health agency" means <u>a person or an entity <del>an</del></u>		216	care facilities licensed under chapter 395, this chapter, or
188	$\overline{\text{organization}}$ that provides $\underline{\text{one or more}}$ home health services $\overline{\text{and}}$		217	chapter 429 or other business entities.
189	staffing services.		218	(22) "Organization" means a corporation, government or
190	(14) "Home health services" means health and medical		219	governmental subdivision or agency, partnership or association,
191	services and medical supplies furnished by an organization to an		220	or any other legal or commercial entity, any of which involve
192	individual in the individual's home or place of residence. The		221	more than one health care professional discipline; a health care
193	term includes organizations that provide one or more of the		222	professional and a home health aide or certified nursing
194	following:		223	assistant; more than one home health aide; more than one
195	(a) Nursing care.		224	certified nursing assistant; or a home health aide and a
196	(b) Physical, occupational, respiratory, or speech therapy.		225	certified nursing assistant. The term does not include an entity
197	(c) Home health aide services.		226	that provides services using only volunteers or only individuals
198	(d) Dietetics and nutrition practice and nutrition		227	related by blood or marriage to the patient or client.
199	counseling.		228	Section 7. Subsections (1), (4), and (5) of section
200	(e) Medical supplies, restricted to drugs and biologicals		229	400.464, Florida Statutes, are amended to read:
201	prescribed by a physician.		230	400.464 Home health agencies to be licensed; expiration of
202	(17) "Home infusion therapy provider" means <u>a person or an</u>		231	license; exemptions; unlawful acts; penalties
203	entity an organization that employs, contracts with, or refers a		232	(1) The requirements of part II of chapter 408 apply to the
	Page 7 of 81			Page 8 of 81
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588-02756-20 20201726c1 262 attorney may, in addition to other remedies provided in this 263 part, bring an action for an injunction to restrain such 264 violation, or to enjoin the future operation or maintenance of 265 the home health agency or the provision of home health services 266 in violation of this part or part II of chapter 408, until 267 compliance with this part or the rules adopted under this part 268 has been demonstrated to the satisfaction of the agency. 269 (c) A person or entity that who violates paragraph (a) is 270 subject to an injunctive proceeding under s. 408.816. A 271 violation of paragraph (a) or s. 408.812 is a deceptive and 272 unfair trade practice and constitutes a violation of the Florida 273 Deceptive and Unfair Trade Practices Act under part II of chapter 501. 274 275 (d) A person or entity that who violates the provisions of 276 paragraph (a) commits a misdemeanor of the second degree. 277 punishable as provided in s. 775.082 or s. 775.083. Any person 278 or entity that who commits a second or subsequent violation 279 commits a misdemeanor of the first degree, punishable as 280 provided in s. 775.082 or s. 775.083. Each day of continuing 281 violation constitutes a separate offense. 282 (e) Any person or entity that who owns, operates, or 283 maintains an unlicensed home health agency and who, after 284 receiving notification from the agency, fails to cease operation 285 and apply for a license under this part commits a misdemeanor of 286 the second degree, punishable as provided in s. 775.082 or s. 287 775.083. Each day of continued operation is a separate offense. 288 (f) Any home health agency that fails to cease operation 289 after agency notification may be fined in accordance with s. 290 408.812.

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588-02756-20 20201726c1 233 provision of services that require licensure pursuant to this 234 part and part II of chapter 408 and entities licensed or 235 registered by or applying for such licensure or registration 236 from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in order to 237 238 operate a home health agency in this state. A license issued on 239 or after July 1, 2018, must specify the home health services the 240 licensee organization is authorized to perform and indicate 241 whether such specified services are considered skilled care. The 242 provision or advertising of services that require licensure 243 pursuant to this part without such services being specified on the face of the license issued on or after July 1, 2018, 244 245 constitutes unlicensed activity as prohibited under s. 408.812. 246 (4) (a) A licensee An organization that offers or advertises 247 to the public any service for which licensure or registration is 248 required under this part must include in the advertisement the 249 license number or registration number issued to the licensee 250 organization by the agency. The agency shall assess a fine of 251 not less than \$100 to any licensee or registrant who fails to 252 include the license or registration number when submitting the 253 advertisement for publication, broadcast, or printing. The fine 254 for a second or subsequent offense is \$500. The holder of a 255 license issued under this part may not advertise or indicate to 256 the public that it holds a home health agency or nurse registry 2.57 license other than the one it has been issued. 258 (b) The operation or maintenance of an unlicensed home 259 health agency or the performance of any home health services in 260 violation of this part is declared a nuisance, inimical to the 261 public health, welfare, and safety. The agency or any state

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Government.

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588-02756-20 20201726c1 20201726c1 (5) The following are exempt from the licensure as a home 320 patients in their homes. health agency under requirements of this part: 321 (d) A home health aide or certified nursing assistant who (a) A home health agency operated by the Federal 322 is acting in his or her individual capacity, within the 323 definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes. (b) Home health services provided by a state agency, either 324 directly or through a contractor with: 325 (e) An individual who acts alone, in his or her individual 1. The Department of Elderly Affairs. 32.6 capacity, and who is not employed by or affiliated with a 2. The Department of Health, a community health center, or 327 licensed home health agency or registered with a licensed nurse a rural health network that furnishes home visits for the 328 registry. This exemption does not entitle an individual to purpose of providing environmental assessments, case management, 329 perform home health services without the required professional health education, personal care services, family planning, or 330 license. followup treatment, or for the purpose of monitoring and 331 (f) The delivery of instructional services in home dialysis tracking disease. 332 and home dialysis supplies and equipment. 3. Services provided to persons with developmental 333 (g) The delivery of nursing home services for which the disabilities, as defined in s. 393.063. 334 nursing home is licensed under part II of this chapter, to serve 4. Companion and sitter organizations that were registered 335 its residents in its facility. under s. 400.509(1) on January 1, 1999, and were authorized to 336 (h) The delivery of assisted living facility services for provide personal services under a developmental services 337 which the assisted living facility is licensed under part I of provider certificate on January 1, 1999, may continue to provide 338 chapter 429, to serve its residents in its facility. such services to past, present, and future clients of the 339 (i) The delivery of hospice services for which the hospice organization who need such services, notwithstanding the is licensed under part IV of this chapter, to serve hospice 340 provisions of this act. 341 patients admitted to its service. 5. The Department of Children and Families. 342 (j) A hospital that provides services for which it is (c) A health care professional, whether or not 343 licensed under chapter 395. (k) The delivery of community residential services for incorporated, who is licensed under chapter 457; chapter 458; 344 which the community residential home is licensed under chapter chapter 459; part I of chapter 464; chapter 467; part I, part 345 III, part V, or part X of chapter 468; chapter 480; chapter 486; 346 419, to serve the residents in its facility. chapter 490; or chapter 491; and who is acting alone within the 347 (1) A not-for-profit, community-based agency that provides scope of his or her professional license to provide care to early intervention services to infants and toddlers. 348 Page 11 of 81 Page 12 of 81 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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349	(m) Certified rehabilitation agencies and comprehensive
350	outpatient rehabilitation facilities that are certified under
351	Title 18 of the Social Security Act.
352	(n) The delivery of adult family-care home services for
353	which the adult family-care home is licensed under part II of
354	chapter 429, to serve the residents in its facility.
355	(o) A person or entity that provides skilled care by health
356	care professionals licensed solely under part I of chapter 464;
357	part I, part III, or part V of chapter 468; or chapter 486.
358	(p) A person or entity that provides services using only
359	volunteers or only individuals related by blood or marriage to
360	the patient or client.
361	Section 8. Paragraph (g) of subsection (2) of section
362	400.471, Florida Statutes, is amended to read:
363	400.471 Application for license; fee
364	(2) In addition to the requirements of part II of chapter
365	408, the initial applicant, the applicant for a change of
366	ownership, and the applicant for the addition of skilled care
367	services must file with the application satisfactory proof that
368	the home health agency is in compliance with this part and
369	applicable rules, including:
370	(g) In the case of an application for initial licensure, an
371	application for a change of ownership, or an application for the
372	addition of skilled care services, documentation of
373	accreditation, or an application for accreditation, from an
374	accrediting organization that is recognized by the agency as
375	having standards comparable to those required by this part and
376	part II of chapter 408. A home health agency that does not
377	provide skilled care is exempt from this paragraph.
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588-02756-20 20201726c1 378 Notwithstanding s. 408.806, the an initial applicant must 379 provide proof of accreditation that is not conditional or 380 provisional and a survey demonstrating compliance with the 381 requirements of this part, part II of chapter 408, and 382 applicable rules from an accrediting organization that is 383 recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days 384 385 after the date of the agency's receipt of the application for 386 licensure. Such accreditation must be continuously maintained by 387 the home health agency to maintain licensure. The agency shall 388 accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is 389 390 recognized by the agency if the accreditation of the licensed 391 home health agency is not provisional and if the licensed home 392 health agency authorizes release of, and the agency receives the 393 report of, the accrediting organization. 394 Section 9. Section 400.492, Florida Statutes, is amended to 395 read: 396 400.492 Provision of services during an emergency.-Each 397 home health agency shall prepare and maintain a comprehensive 398 emergency management plan that is consistent with the standards 399 adopted by national or state accreditation organizations and 400 consistent with the local special needs plan. The plan shall be 401 updated annually and shall provide for continuing home health 402 services during an emergency that interrupts patient care or 403 services in the patient's home. The plan shall include the means 404 by which the home health agency will continue to provide staff 405 to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being 406

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CS for SB 1726

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provided to those patients prior to evacuation. Th	e plan shall	436	skilled nursing services and the patient's medication and
describe how the home health agency establishes an	d maintains an	437	equipment needs. The list shall be furnished to county health
effective response to emergencies and disasters, i	ncluding:	438	departments and to local emergency management agencies, upon
notifying staff when emergency response measures a	re initiated;	439	request.
providing for communication between staff members,	county health	440	(3) Home health agencies shall not be required to continue
departments, and local emergency management agenci	es, including	441	to provide care to patients in emergency situations that are
a backup system; identifying resources necessary t	o continue	442	beyond their control and that make it impossible to provide
essential care or services or referrals to other <u>h</u>	ealth care	443	services, such as when roads are impassable or when patients do
providers organizations subject to written agreeme	nt; and	444	not go to the location specified in their patient records. Home
prioritizing and contacting patients who need cont	inued care or	445	health agencies may establish links to local emergency
services.		446	operations centers to determine a mechanism by which to approach
(1) Each patient record for patients who are	listed in the	447	specific areas within a disaster area in order for the agency to
registry established pursuant to s. 252.355 shall	include a	448	reach its clients. Home health agencies shall demonstrate a good
description of how care or services will be contin	ued in the	449	faith effort to comply with the requirements of this subsection
event of an emergency or disaster. The home health	agency shall	450	by documenting attempts of staff to follow procedures outlined
discuss the emergency provisions with the patient	and the	451	in the home health agency's comprehensive emergency management
patient's caregivers, including where and how the	patient is to	452	plan, and by the patient's record, which support a finding that
evacuate, procedures for notifying the home health	agency in the	453	the provision of continuing care has been attempted for those
event that the patient evacuates to a location oth	er than the	454	patients who have been identified as needing care by the home
shelter identified in the patient record, and a li	st of	455	health agency and registered under s. 252.355, in the event of
medications and equipment which must either accomp	any the	456	an emergency or disaster under subsection (1).
patient or will be needed by the patient in the ev	ent of an	457	(4) Notwithstanding the provisions of s. 400.464(2) or any
evacuation.		458	other provision of law to the contrary, a home health agency may
(2) Each home health agency shall maintain a	current	459	provide services in a special needs shelter located in any
prioritized list of patients who need continued se	rvices during	460	county.
an emergency. The list shall indicate how services	shall be	461	Section 10. Subsection (4) and paragraph (a) of subsection
continued in the event of an emergency or disaster	for each	462	(5) of section 400.506, Florida Statutes, are amended to read:
patient and if the patient is to be transported to	a special	463	400.506 Licensure of nurse registries; requirements;
needs shelter, and shall indicate if the patient i	s receiving	464	penalties
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raye 13 01 01			raye to or or

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408 describe how the home health agency establi 409 effective response to emergencies and disas 410 notifying staff when emergency response mea providing for communication between staff me 411 departments, and local emergency management 412 a backup system; identifying resources nece 413 414 essential care or services or referrals to 415 providers organizations subject to written prioritizing and contacting patients who ne 416 417 services. 418 (1) Each patient record for patients w 419 registry established pursuant to s. 252.355 420 description of how care or services will be 421 event of an emergency or disaster. The home 422 discuss the emergency provisions with the p 423 patient's caregivers, including where and h 424 evacuate, procedures for notifying the home 425 event that the patient evacuates to a locat. 426 shelter identified in the patient record, a 427 medications and equipment which must either 428 patient or will be needed by the patient in 429 evacuation. 430 (2) Each home health agency shall main 431 prioritized list of patients who need conti an emergency. The list shall indicate how s 432 433 continued in the event of an emergency or d 434 patient and if the patient is to be transpo. 435 needs shelter, and shall indicate if the pa

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588-02756-20 20201726c1 588-02756-20 20201726c1 465 (4) A licensee who person that provides, offers, or 494 developmental disability, as defined in s. 393.063, is exempt 466 advertises to the public any service for which licensure is 495 from registration. 467 required under this section must include in such advertisement 496 (2) The requirements of part II of chapter 408 apply to the 468 the license number issued to the licensee it by the Agency for 497 provision of services that require registration or licensure 469 Health Care Administration. The agency shall assess a fine of 498 pursuant to this section and part II of chapter 408 and entities 470 not less than \$100 against any licensee who fails to include the 499 registered by or applying for such registration from the Agency 471 license number when submitting the advertisement for 500 for Health Care Administration pursuant to this section. Each 472 publication, broadcast, or printing. The fine for a second or 501 applicant for registration and each registrant must comply with 473 subsequent offense is \$500. 502 all provisions of part II of chapter 408. Registration or a 474 (5) (a) In addition to the requirements of s. 408.812, any 503 license issued by the agency is required for a person or an 475 person or entity that who owns, operates, or maintains an 504 entity to provide the operation of an organization that provides 476 unlicensed nurse registry and who, after receiving notification 505 companion services or homemaker services. from the agency, fails to cease operation and apply for a (4) Each registrant must obtain the employment or contract 477 506 478 license under this part commits a misdemeanor of the second 507 history of persons who are employed by or under contract with 479 degree, punishable as provided in s. 775.082 or s. 775.083. Each 508 the person or entity organization and who will have contact at 480 day of continued operation is a separate offense. 509 any time with patients or clients in their homes by: 481 Section 11. Subsections (1), (2), (4), and (5) of section 510 (a) Requiring such persons to submit an employment or 482 400.509, Florida Statutes, are amended to read: 511 contractual history to the registrant; and 483 400.509 Registration of particular service providers exempt 512 (b) Verifying the employment or contractual history, unless 484 from licensure; certificate of registration; regulation of 513 through diligent efforts such verification is not possible. The 485 registrants.-514 agency shall prescribe by rule the minimum requirements for 486 (1) Any person or entity organization that provides 515 establishing that diligent efforts have been made. 487 companion services or homemaker services and does not provide a 516 488 home health service to a person is exempt from licensure under 517 There is no monetary liability on the part of, and no cause of 489 this part. However, any person or entity organization that 518 action for damages arises against, a former employer of a 490 provides companion services or homemaker services must register 519 prospective employee of or prospective independent contractor 491 with the agency. A person or an entity An organization under 520 with a registrant who reasonably and in good faith communicates 492 contract with the Agency for Persons with Disabilities which 521 his or her honest opinions about the former employee's or 493 contractor's job performance. This subsection does not affect provides companion services only for persons with a 522 Page 17 of 81 Page 18 of 81 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions. 523

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the official immunity of an officer or	employee of a public		552	compare such measures of one or more ho	spices.
corporation.			553	(b) Develop an annual report that	analyzes and evaluates
(5) A person or an entity that off	ers or advertises to the		554	the information collected under this ac	t and any other data
public a service for which registration	is required must include		555	collection or reporting provisions of 1	<del>aw.</del>
in its advertisement the registration r	number issued by the		556	Section 14. Subsection (4) of sect	ion 400.9905, Florida
Agency for Health Care Administration.			557	Statutes, is amended to read:	
Section 12. Subsection (3) of sect	ion 400.605, Florida		558	400.9905 Definitions	
Statutes, is amended to read:			559	(4) "Clinic" means an entity where	health care services are
400.605 Administration; forms; fee	es; rules; inspections;		560	provided to individuals and which tende	rs charges for
fines			561	reimbursement for such services, includ	ing a mobile clinic and a
(3) In accordance with s. 408.811,	the agency shall conduct		562	portable equipment provider. As used in	this part, the term does
annual inspections of all licensees, ex	cept that licensure		563	not include and the licensure requireme	nts of this part do not
inspections may be conducted biennially	for hospices having a 3-		564	apply to:	
year record of substantial compliance.	The agency shall conduct		565	(a) Entities licensed or registere	d by the state under
such inspections and investigations as	are necessary in order to		566	chapter 395; entities licensed or regis	tered by the state and
determine the state of compliance with	the provisions of this		567	providing only health care services wit	hin the scope of services
part, part II of chapter 408, and appli	cable rules.		568	authorized under their respective licen	ses under ss. 383.30-
Section 13. Section 400.60501, Flo	orida Statutes, is amended		569	383.332, chapter 390, chapter 394, chap	ter 397, this chapter
to read:			570	except part X, chapter 429, chapter 463	, chapter 465, chapter
400.60501 Outcome measures; adopti	on of federal quality		571	466, chapter 478, chapter 484, or chapt	er 651; end-stage renal
measures; public reporting; annual repo	ert		572	disease providers authorized under 42 C	.F.R. part 405, subpart
(1) No later than December 31, 201	$\Theta_r$ The agency shall adopt		573	U; providers certified and providing on	ly health care services
the national hospice outcome measures a	nd survey data in 42		574	within the scope of services authorized	under their respective
C.F.R. part 418 to determine the qualit	y and effectiveness of		575	certifications under 42 C.F.R. part 485	, subpart B <u>,</u> <del>or</del> subpart
hospice care for hospices licensed in t	the state.		576	H, or subpart J; providers certified an	d providing only health
(2) The agency shall <del>:</del>			577	care services within the scope of servi	ces authorized under
<del>(a)</del> make available to the public t	he national hospice		578	their respective certifications under 4	2 C.F.R. part 486,
outcome measures and survey data in a f	format that is		579	subpart C; providers certified and prov	iding only health care
comprehensible by a layperson and that	allows a consumer to		580	services within the scope of services a	uthorized under their
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respective certifications under 42 C.F.R. part 491, subpart A;	610	Amendments and the federal rules adopted thereunder; or any
providers certified by the Centers for Medicare and Medicaid	611	entity that provides neonatal or pediatric hospital-based health
services under the federal Clinical Laboratory Improvement	612	care services by licensed practitioners solely within a hospital
Amendments and the federal rules adopted thereunder; or any	613	licensed under chapter 395.
entity that provides neonatal or pediatric hospital-based health	614	(c) Entities that are owned, directly or indirectly, by an
care services or other health care services by licensed	615	entity licensed or registered by the state pursuant to chapter
practitioners solely within a hospital licensed under chapter	616	395; entities that are owned, directly or indirectly, by an
395.	617	entity licensed or registered by the state and providing only
(b) Entities that own, directly or indirectly, entities	618	health care services within the scope of services authorized
licensed or registered by the state pursuant to chapter 395;	619	pursuant to their respective licenses under ss. 383.30-383.332,
entities that own, directly or indirectly, entities licensed or	620	chapter 390, chapter 394, chapter 397, this chapter except part
registered by the state and providing only health care services	621	X, chapter 429, chapter 463, chapter 465, chapter 466, chapter
within the scope of services authorized pursuant to their	622	478, chapter 484, or chapter 651; end-stage renal disease
respective licenses under ss. 383.30-383.332, chapter 390,	623	providers authorized under 42 C.F.R. part 405, subpart U;
chapter 394, chapter 397, this chapter except part X, chapter	624	providers certified and providing only health care services
429, chapter 463, chapter 465, chapter 466, chapter 478, chapter	625	within the scope of services authorized under their respective
484, or chapter 651; end-stage renal disease providers	626	certifications under 42 C.F.R. part 485, subpart B <u>,</u> <del>or</del> subpart
authorized under 42 C.F.R. part 405, subpart U; providers	627	H, or subpart J; providers certified and providing only health
certified and providing only health care services within the	628	care services within the scope of services authorized under
scope of services authorized under their respective	629	their respective certifications under 42 C.F.R. part 486,
certifications under 42 C.F.R. part 485, subpart B <u>,</u> <del>or</del> subpart	630	subpart C; providers certified and providing only health care
H, or subpart J; providers certified and providing only health	631	services within the scope of services authorized under their
care services within the scope of services authorized under	632	respective certifications under 42 C.F.R. part 491, subpart A;
their respective certifications under 42 C.F.R. part 486,	633	providers certified by the Centers for Medicare and Medicaid
subpart C; providers certified and providing only health care	634	services under the federal Clinical Laboratory Improvement
services within the scope of services authorized under their	635	Amendments and the federal rules adopted thereunder; or any
respective certifications under 42 C.F.R. part 491, subpart A;	636	entity that provides neonatal or pediatric hospital-based health
providers certified by the Centers for Medicare and Medicaid	637	care services by licensed practitioners solely within a hospital
services under the federal Clinical Laboratory Improvement	638	under chapter 395.
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588-02756-20 20201726c1 two-thirds of which are Florida-licensed health care 668 669 practitioners and provides only physical therapy services under 670 physician orders, any community college or university clinic, 671 and any entity owned or operated by the federal or state 672 government, including agencies, subdivisions, or municipalities 673 thereof. 674 (f) A sole proprietorship, group practice, partnership, or 675 corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or 676 677 more of such physicians, and that is wholly owned by one or more 678 of those physicians or by a physician and the spouse, parent, 679 child, or sibling of that physician. 680 (q) A sole proprietorship, group practice, partnership, or 681 corporation that provides health care services by licensed 682 health care practitioners under chapter 457, chapter 458, 683 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, 684 685 chapter 490, chapter 491, or part I, part III, part X, part 686 XIII, or part XIV of chapter 468, or s. 464.012, and that is 687 wholly owned by one or more licensed health care practitioners, 688 or the licensed health care practitioners set forth in this 689 paragraph and the spouse, parent, child, or sibling of a 690 licensed health care practitioner if one of the owners who is a 691 licensed health care practitioner is supervising the business 692 activities and is legally responsible for the entity's 693 compliance with all federal and state laws. However, a health 694 care practitioner may not supervise services beyond the scope of 695 the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) 696 Page 24 of 81 CODING: Words stricken are deletions; words underlined are additions.

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639 (d) Entities that are under common ownership, directly or 640 indirectly, with an entity licensed or registered by the state 641 pursuant to chapter 395; entities that are under common 642 ownership, directly or indirectly, with an entity licensed or 643 registered by the state and providing only health care services 644 within the scope of services authorized pursuant to their 645 respective licenses under ss. 383.30-383.332, chapter 390, 646 chapter 394, chapter 397, this chapter except part X, chapter 647 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 648 484, or chapter 651; end-stage renal disease providers 649 authorized under 42 C.F.R. part 405, subpart U; providers 650 certified and providing only health care services within the 651 scope of services authorized under their respective 652 certifications under 42 C.F.R. part 485, subpart B, or subpart 653 H, or subpart J; providers certified and providing only health care services within the scope of services authorized under 654 655 their respective certifications under 42 C.F.R. part 486, 656 subpart C; providers certified and providing only health care 657 services within the scope of services authorized under their 658 respective certifications under 42 C.F.R. part 491, subpart A; 659 providers certified by the Centers for Medicare and Medicaid 660 services under the federal Clinical Laboratory Improvement 661 Amendments and the federal rules adopted thereunder; or any 662 entity that provides neonatal or pediatric hospital-based health 663 care services by licensed practitioners solely within a hospital 664 licensed under chapter 395. 665 (e) An entity that is exempt from federal taxation under 26 666 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 667

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which provides only services authorized pursuant to s.	72.6	
456.053(3)(b) may be supervised by a licensee specified in s.	727	
456.053(3) (b).	728	(m) Entities that are owned by a corporation that has \$250
(h) Clinical facilities affiliated with an accredited	729	million or more in total annual sales of health care services
medical school at which training is provided for medical	730	provided by licensed health care practitioners where one or more
students, residents, or fellows.	731	of the persons responsible for the operations of the entity is a
(i) Entities that provide only oncology or radiation	732	health care practitioner who is licensed in this state and who
therapy services by physicians licensed under chapter 458 or	733	is responsible for supervising the business activities of the
chapter 459 or entities that provide oncology or radiation	734	entity and is responsible for the entity's compliance with state
therapy services by physicians licensed under chapter 458 or	735	law for purposes of this part.
chapter 459 which are owned by a corporation whose shares are	736	(n) Entities that employ 50 or more licensed health care
publicly traded on a recognized stock exchange.	737	practitioners licensed under chapter 458 or chapter 459 where
(j) Clinical facilities affiliated with a college of	738	the billing for medical services is under a single tax
chiropractic accredited by the Council on Chiropractic Education	739	identification number. The application for exemption under this
at which training is provided for chiropractic students.	740	subsection shall contain information that includes: the name,
(k) Entities that provide licensed practitioners to staff	741	residence, and business address and phone number of the entity
emergency departments or to deliver anesthesia services in	742	that owns the practice; a complete list of the names and contact
facilities licensed under chapter 395 and that derive at least	743	information of all the officers and directors of the
90 percent of their gross annual revenues from the provision of	744	corporation; the name, residence address, business address, and
such services. Entities claiming an exemption from licensure	745	medical license number of each licensed Florida health care
under this paragraph must provide documentation demonstrating	746	practitioner employed by the entity; the corporate tax
compliance.	747	identification number of the entity seeking an exemption; a
(1) Orthotic, prosthetic, pediatric cardiology, or	748	listing of health care services to be provided by the entity at
perinatology clinical facilities or anesthesia clinical	749	the health care clinics owned or operated by the entity and a
facilities that are not otherwise exempt under paragraph (a) or	750	certified statement prepared by an independent certified public
paragraph (k) and that are a publicly traded corporation or are	751	accountant which states that the entity and the health care
wholly owned, directly or indirectly, by a publicly traded	752	clinics owned or operated by the entity have not received
corporation. As used in this paragraph, a publicly traded	753	payment for health care services under personal injury
corporation is a corporation that issues securities traded on an	754	protection insurance coverage for the preceding year. If the
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588-02756-20 20201726c1 755 agency determines that an entity which is exempt under this 756 subsection has received payments for medical services under 757 personal injury protection insurance coverage, the agency may 758 deny or revoke the exemption from licensure under this 759 subsection. 760 (o) Entities that are, directly or indirectly, under the 761 common ownership of or that are subject to common control by a 762 mutual insurance holding company, as defined in s. 628.703, with 763 an entity licensed or certified under chapter 627 or chapter 641 764 which has \$1 billion or more in total annual sales in this 765 state. 766 (p) Entities that are owned by an entity that is a 767 behavioral health service provider in at least 5 states other 768 than Florida and that, together with its affiliates, has \$90 769 million or more in total annual revenues associated with the 770 provision of behavioral health services and where one or more of 771 the persons responsible for the operations of the entity is a 772 health care practitioner who is licensed in this state and who 773 is responsible for supervising the business activities of the 774 entity and who is responsible for the entity's compliance with 775 state law for purposes of this part. 776 (q) Medicaid providers. 777 778 Notwithstanding this subsection, an entity shall be deemed a 779 clinic and must be licensed under this part in order to receive 780 reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 781 627.730-627.7405, unless exempted under s. 627.736(5)(h). 782 Section 15. Paragraph (c) of subsection (3) of section 783 400.991, Florida Statutes, is amended to read: Page 27 of 81 CODING: Words stricken are deletions; words underlined are additions.

588-02756-20 20201726c1 784 400.991 License requirements; background screenings; 785 prohibitions.-786 (3) In addition to the requirements of part II of chapter 787 408, the applicant must file with the application satisfactory 788 proof that the clinic is in compliance with this part and 789 applicable rules, including: 790 (c) Proof of financial ability to operate as required under 791 ss. 408.8065(1) and 408.810(8) s. 408.810(8). As an alternative 792 to submitting proof of financial ability to operate as required 793 under s. 408.810(8), the applicant may file a surety bond of at 794 least \$500,000 which guarantees that the clinic will act in full 795 conformity with all legal requirements for operating a clinic, 796 payable to the agency. The agency may adopt rules to specify 797 related requirements for such surety bond. 798 Section 16. Paragraph (i) of subsection (1) of section 799 400.9935, Florida Statutes, is amended to read: 800 400.9935 Clinic responsibilities.-801 (1) Each clinic shall appoint a medical director or clinic 802 director who shall agree in writing to accept legal 803 responsibility for the following activities on behalf of the 804 clinic. The medical director or the clinic director shall: 805 (i) Ensure that the clinic publishes a schedule of charges 806 for the medical services offered to patients. The schedule must 807 include the prices charged to an uninsured person paying for 808 such services by cash, check, credit card, or debit card. The 809 schedule may group services by price levels, listing services in 810 each price level. The schedule must be posted in a conspicuous 811 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, 812

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588-02756-202020172c1588-02756-2020213but is not limited to, the 50 services most frequently provided842reporting; information relating to physician charges;14by the clinic. The schedule may group services by three price843confidential information; immunity15levels, listing services in each price level. The posting may be844(1) The agency shall require the submission by health16a sign that must be at least 15 square feet in size or through845facilities, health care providers, and health insurers of17an electronic messaging board that is at least 3 square feet in846necessary to carry out the agency's duties and to facilitation18size. The failure of a clinic, including a clinic that is an847transparency in health care pricing data and quality measure19urgent care center, to publish and post a schedule of charges as848Specifications for data to be collected under this section19urgent day this section shall result in a fine of not more than849be developed by the agency and applicable contract vendors	lata
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 but is not limited to, the 50 services most frequently provided by the clinic, including a clinic that is an by the clinic that is at least 3 square feet an by the clinic that is an by the clinic for the schedule of charges as by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for the clinic for the clinic for data to be collected under the clinic for the c	care lata
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 but is not limited to, the 50 services most frequently provided by the clinic, including a clinic that is an by the clinic that is at least 3 square feet an by the clinic that is an by the clinic for the schedule of charges as by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for data to be collected under this section by the clinic for the clinic for the clinic for data to be collected under the clinic for the c	care lata
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 <u>urgent care center</u> , to publish and post a schedule of charges as by the clinic. The schedule may group services by three price by the clinic. The schedule may group services by three price by the clinic. The schedule may group services by three price by the clinic. The schedule may group services by three price by the clinic. The schedule may group services by three price by the clinic may group services by three price by 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 by the clinic, including a clinic that is an by the clinic may group services by three price by the posting may be by the clinic may group services by three price by the clinic may group services by three price by the clinic may group services by three price by the posting may be by the clinic may group services by three price by the posting may be by the clinic may group services by three price by the posting may be by the clinic may group services by three price by the posting may be by the clinic may group services by three price by the posting may be by the clinic may group services by three price by the posting may be by the clinic may group services by three price by t	lata
15Levels, listing services in each price level. The posting may be844(1) The agency shall require the submission by health16a sign that must be at least 15 square feet in size or through845facilities, health care providers, and health insurers of17an electronic messaging board that is at least 3 square feet in846necessary to carry out the agency's duties and to facilita18size. The failure of a clinic, including a clinic that is an847transparency in health care pricing data and quality measu19urgent care center, to publish and post a schedule of charges as848Specifications for data to be collected under this section	lata
a sign that must be at least 15 square feet in size or through845facilities, health care providers, and health insurers ofan electronic messaging board that is at least 3 square feet in846necessary to carry out the agency's duties and to facilitasize. The failure of a clinic, including a clinic that is an847transparency in health care pricing data and quality measuurgent care center, to publish and post a schedule of charges as848Specifications for data to be collected under this section	lata
17an electronic messaging board that is at least 3 square feet in846necessary to carry out the agency's duties and to facilita18size. The failure of a clinic, including a clinic that is an847transparency in health care pricing data and quality measu19urgent care center, to publish and post a schedule of charges as848Specifications for data to be collected under this section	
18       size. The failure of a clinic, including a clinic that is an       847       transparency in health care pricing data and quality measu         19       urgent care center, to publish and post a schedule of charges as       848       Specifications for data to be collected under this section	e
urgent care center, to publish and post a schedule of charges as 848 Specifications for data to be collected under this section	
	es.
required by this section shall result in a fine of not more than 849 be developed by the agency and applicable contract vendors	shall
	with
\$1,000, per day, until the schedule is published and posted. 850 the assistance of technical advisory panels including	
22 Section 17. Paragraph (a) of subsection (2) of section 851 representatives of affected entities, consumers, purchaser	, and
408.033, Florida Statutes, is amended to read: 852 such other interested parties as may be determined by the	
408.033 Local and state health planning 853 agency.	
25 (2) FUNDING 854 (a) Data submitted by health care facilities, includi	g the
(a) The Legislature intends that the cost of local health 855 facilities as defined in chapter 395, shall include, but a	e not
councils be borne by assessments on selected health care 856 limited to <u>,</u> + case-mix data, patient admission and discharg	
facilities subject to facility licensure by the Agency for 857 data, hospital emergency department data which shall inclu	e the
Health Care Administration, including abortion clinics, assisted 858 number of patients treated in the emergency department of	÷
1 living facilities, ambulatory surgical centers, birth centers, 859 licensed hospital reported by patient acuity level, data c	i.
home health agencies, hospices, hospitals, intermediate care 860 hospital-acquired infections as specified by rule, data on	
facilities for the developmentally disabled, nursing homes, and 861 complications as specified by rule, data on readmissions a	
health care clinics, and multiphasic testing centers and by 862 specified by rule, including patient- with patient and pro	ider-
assessments on organizations subject to certification by the 863 specific identifiers included, actual charge data by diagn	stic
agency pursuant to chapter 641, part III, including health 864 groups or other bundled groupings as specified by rule,	
maintenance organizations and prepaid health clinics. Fees 865 financial data, accounting data, operating expenses, expen	es
assessed may be collected prospectively at the time of licensure 866 incurred for rendering services to patients who cannot or	o not.
renewal and prorated for the licensure period. 867 pay, interest charges, depreciation expenses based on the	
Section 18. Paragraph (a) of subsection (1) of section 868 expected useful life of the property and equipment involve	, and
408.061, Florida Statutes, is amended to read: 869 demographic data. The agency shall adopt nationally recogn	zed
408.061 Data collection; uniform systems of financial 870 risk adjustment methodologies or software consistent with	he
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588-02756-20 20201726c1 900 408.062 Research, analyses, studies, and reports .-901 (1) The agency shall conduct research, analyses, and 902 studies relating to health care costs and access to and quality 903 of health care services as access and quality are affected by 904 changes in health care costs. Such research, analyses, and studies shall include, but not be limited to: 905 906 (i) The use of emergency department services by patient 907 acuity level and the implication of increasing hospital cost by providing nonurgent care in emergency departments. The agency 908 909 shall publish annually on its website information submit an 910 annual report based on this monitoring and assessment to the Governor, the Speaker of the House of Representatives, the 911 912 President of the Senate, and the substantive legislative 913 committees, due January 1. 914 (i) The making available on its Internet website, and in a 915 hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health 916 917 care facilities pursuant to s. 408.061(1)(a) for specific 918 medical conditions, surgeries, and procedures provided in 919 inpatient and outpatient facilities as determined by the agency. 920 In making the determination of specific medical conditions, 921 surgeries, and procedures to include, the agency shall consider 922 such factors as volume, severity of the illness, urgency of 923 admission, individual and societal costs, and whether the 92.4 condition is acute or chronic. Performance outcome indicators 925 shall be risk adjusted or severity adjusted, as applicable, 926 using nationally recognized risk adjustment methodologies or 927 software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. 928 Page 32 of 81 CODING: Words stricken are deletions; words underlined are additions.

588-02756-20 20201726c1 871 standards of the Agency for Healthcare Research and Quality and 872 as selected by the agency for all data submitted as required by 873 this section. Data may be obtained from documents including such 874 as, but not limited to, + leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, 875 and related diagnostic information. Reported Data elements shall 876 877 be reported electronically in accordance with the inpatient data 878 reporting instructions as prescribed by agency rule 59E-7.012, 879 Florida Administrative Code. Data submitted shall be certified 880 by the chief executive officer or an appropriate and duly 881 authorized representative or employee of the licensed facility that the information submitted is true and accurate. 882 883 Section 19. Subsection (4) of section 408.0611, Florida 884 Statutes, is amended to read: 885 408.0611 Electronic prescribing clearinghouse.-886 (4) Pursuant to s. 408.061, the agency shall monitor the 887 implementation of electronic prescribing by health care 888 practitioners, health care facilities, and pharmacies. By 889 January 31 of each year, The agency shall report annually on its 890 website on the progress of implementation of electronic 891 prescribing to the Governor and the Legislature. Information 892 reported pursuant to this subsection must shall include federal 893 and private sector electronic prescribing initiatives and, to 894 the extent that data is readily available from organizations 895 that operate electronic prescribing networks, the number of 896 health care practitioners using electronic prescribing and the 897 number of prescriptions electronically transmitted. 898 Section 20. Paragraphs (i) and (j) of subsection (1) of 899 section 408.062, Florida Statutes, are amended to read: Page 31 of 81

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588-02756-20 20201726c1 929 The website shall also provide an interactive search that allows 930 consumers to view and compare the information for specific 931 facilities, a map that allows consumers to select a county or 932 region, definitions of all of the data, descriptions of each 933 procedure, and an explanation about why the data may differ from 934 facility to facility. Such public data shall be updated 935 quarterly. The agency shall publish annually on its website 936 information submit an annual status report on the collection of 937 data and publication of health care quality measures to the 938 Governor, the Speaker of the House of Representatives, the 939 President of the Senate, and the substantive legislative 940 committees, due January 1. 941 Section 21. Subsection (5) of section 408.063, Florida Statutes, is amended to read: 942 943 408.063 Dissemination of health care information .-(5) The agency shall publish annually a comprehensive 944 945 report of state health expenditures. The report shall identify: 946 (a) The contribution of health care dollars made by all 947 payors. 948 (b) The dollars expended by type of health care service in 949 Florida. 950 Section 22. Section 408.802, Florida Statutes, is amended 951 to read: 952 408.802 Applicability.-The provisions of This part applies 953 apply to the provision of services that require licensure as 954 defined in this part and to the following entities licensed, 955 registered, or certified by the agency, as described in chapters 956 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765: 957 (1) Laboratories authorized to perform testing under the Page 33 of 81 CODING: Words stricken are deletions; words underlined are additions.

588-02756-20 20201726c1 958 Drug-Free Workplace Act, as provided under ss. 112.0455 and 959 440.102. 960 (2) Birth centers, as provided under chapter 383. 961 (3) Abortion clinics, as provided under chapter 390. 962 (4) Crisis stabilization units, as provided under parts I and IV of chapter 394. 963 964 (5) Short-term residential treatment facilities, as 965 provided under parts I and IV of chapter 394. (6) Residential treatment facilities, as provided under 966 967 part IV of chapter 394. 968 (7) Residential treatment centers for children and 969 adolescents, as provided under part IV of chapter 394. (8) Hospitals, as provided under part I of chapter 395. 970 971 (9) Ambulatory surgical centers, as provided under part I 972 of chapter 395. 973 (10) Nursing homes, as provided under part II of chapter 974 400. 975 (11) Assisted living facilities, as provided under part I 976 of chapter 429. 977 (12) Home health agencies, as provided under part III of 978 chapter 400. 979 (13) Nurse registries, as provided under part III of chapter 400. 980 981 (14) Companion services or homemaker services providers, as 982 provided under part III of chapter 400. 983 (15) Adult day care centers, as provided under part III of 984 chapter 429. 985 (16) Hospices, as provided under part IV of chapter 400. 986 (17) Adult family-care homes, as provided under part II of

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588-02756-20 20201726c1 588-02756-20 20201726c1 1016 987 chapter 429. and 765. 988 (18) Homes for special services, as provided under part  ${\tt V}$ 1017 (10) "Low-risk provider" means nurse registries, home 989 of chapter 400. 1018 medical equipment providers, and health care clinics. 990 (19) Transitional living facilities, as provided under part 1019 Section 24. Paragraph (b) of subsection (7) of section 991 XI of chapter 400. 1020 408.806, Florida Statutes, is amended to read: 992 (20) Prescribed pediatric extended care centers, as 1021 408.806 License application process .-993 provided under part VI of chapter 400. 1022 (7)994 (21) Home medical equipment providers, as provided under 1023 (b) An initial inspection is not required for companion 995 1024 services or homemaker services providers_{$\tau$} as provided under part part VII of chapter 400. 996 (22) Intermediate care facilities for persons with 1025 III of chapter 400,  $\frac{1}{2}$  or health care services pools, as 997 developmental disabilities, as provided under part VIII of 1026 provided under part IX of chapter 400, or for low-risk providers 998 chapter 400. 1027 as provided under s. 408.811. 999 1028 Section 25. Subsection (2) of section 408.808, Florida (23) Health care services pools, as provided under part IX 1000 of chapter 400. 1029 Statutes, is amended to read: 1001 (24) Health care clinics, as provided under part X of 1030 408.808 License categories .-1002 1031 chapter 400. (2) PROVISIONAL LICENSE. - An applicant against whom a 1003 (25) Multiphasic health testing centers, as provided under proceeding denying or revoking a license is pending at the time 1032 1004 of license renewal may be issued a provisional license effective part I of chapter 483. 1033 1005 (25) (26) Organ, tissue, and eye procurement organizations, 1034 until final action not subject to further appeal. A provisional 1006 as provided under part V of chapter 765. 1035 license may also be issued to an applicant for initial licensure 1007 1036 or applying for a change of ownership. A provisional license Section 23. Present subsections (10) through (14) of 1008 section 408.803, Florida Statutes, are redesignated as 1037 must be limited in duration to a specific period of time, up to 1009 subsections (11) through (15), respectively, a new subsection 1038 12 months, as determined by the agency. 1010 (10) is added to that section, and subsection (3) of that 1039 Section 26. Subsections (2) and (5) of section 408.809, 1011 section is amended, to read: 1040 Florida Statutes, are amended to read: 1012 408.803 Definitions.-As used in this part, the term: 1041 408.809 Background screening; prohibited offenses .-1013 (3) "Authorizing statute" means the statute authorizing the 1042 (2) Every 5 years following his or her licensure, 1014 licensed operation of a provider listed in s. 408.802 and 1043 employment, or entry into a contract in a capacity that under 1015 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, subsection (1) would require level 2 background screening under 1044 Page 35 of 81 Page 36 of 81 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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	1074	Department of Financial Services for an applicant for a
	1075	certificate of authority or provisional certificate of authority
	1076	to operate a continuing care retirement community under chapter
	1077	651, provided that:
	1078	(a) The screening standards and disqualifying offenses for
	1079	the prior screening are equivalent to those specified in s.
	1080	435.04 and this section;
	1081	(b) The person subject to screening has not had a break in
	1082	service from a position that requires level 2 screening for more
	1083	than 90 days; and
	1084	(c) Such proof is accompanied, under penalty of perjury, by
	1085	an attestation of compliance with chapter 435 and this section
	1086	using forms provided by the agency.
	1087	(5) A person who serves as a controlling interest of, is
	1088	employed by, or contracts with a licensee on July 31, 2010, who
	1089	has been screened and qualified according to standards specified
	1090	in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,
	1091	in compliance with the following schedule. If, upon rescreening,
	1092	such person has a disqualifying offense that was not a
	1093	disqualifying offense at the time of the last screening, but is
	1094	a current disqualifying offense and was committed before the
	1095	last screening, he or she may apply for an exemption from the
	1096	appropriate licensing agency and, if agreed to by the employer,
	1097	may continue to perform his or her duties until the licensing
	1098	agency renders a decision on the application for exemption if
	1099	the person is eligible to apply for an exemption and the
	1100	exemption request is received by the agency within 30 days after
	1101	receipt of the rescreening results by the person. The
	1102	rescreening schedule shall be:

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588-02756-20 20201726c1 1045 chapter 435, each such person must submit to level 2 background 1046 rescreening as a condition of retaining such license or 1047 continuing in such employment or contractual status. For any 1048 such rescreening, the agency shall request the Department of Law 1049 Enforcement to forward the person's fingerprints to the Federal 1050 Bureau of Investigation for a national criminal history record 1051 check unless the person's fingerprints are enrolled in the 1052 Federal Bureau of Investigation's national retained print arrest 1053 notification program. If the fingerprints of such a person are 1054 not retained by the Department of Law Enforcement under s. 1055 943.05(2)(g) and (h), the person must submit fingerprints 1056 electronically to the Department of Law Enforcement for state 1057 processing, and the Department of Law Enforcement shall forward 1058 the fingerprints to the Federal Bureau of Investigation for a 1059 national criminal history record check. The fingerprints shall 1060 be retained by the Department of Law Enforcement under s. 1061 943.05(2)(q) and (h) and enrolled in the national retained print 1062 arrest notification program when the Department of Law 1063 Enforcement begins participation in the program. The cost of the 1064 state and national criminal history records checks required by 1065 level 2 screening may be borne by the licensee or the person 1066 fingerprinted. Until a specified agency is fully implemented in 1067 the clearinghouse created under s. 435.12, The agency may accept 1068 as satisfying the requirements of this section proof of 1069 compliance with level 2 screening standards submitted within the 1070 previous 5 years to meet any provider or professional licensure 1071 requirements of the agency, the Department of Health, the 1072 Department of Elderly Affairs, the Agency for Persons with 1073 Disabilities, the Department of Children and Families, or the Page 37 of 81

(b) Inspections for relicensure shall be conducted

(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

licensure inspections for at least 10 percent of exempt low-risk

an extended period between relicensure inspections for specific

2. Outcome measures that demonstrate quality performance.

by rule. The agency shall continue to conduct unannounced

(d) The agency may adopt rules to waive a routine inspection, including inspection for relicensure, or allow for

1. A favorable regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory

3. Successful participation in a recognized quality

5. Other measures reflective of quality and safety.

inspections for at least 10 percent of providers that qualify

for a waiver or extended period between relicensure inspections.

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(e) The agency maintains the authority to conduct an inspection of any provider at any time to determine regulatory

The agency shall continue to conduct unannounced licensure

6. The length of time between inspections.

biennially unless otherwise specified by this section,

authorizing statutes, or applicable rules.

providers to verify compliance.

4. Accreditation status.

providers based upon:

assurance program.

measures.

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1103	(a) Individuals for whom the last screening was conducted
1104	on or before December 31, 2004, must be rescreened by July 31,
1105	<del>2013.</del>
1106	(b) Individuals for whom the last screening conducted was
1107	between January 1, 2005, and December 31, 2008, must be
1108	reservened by July 31, 2014.
1109	(c) Individuals for whom the last screening conducted was
1110	between January 1, 2009, through July 31, 2011, must be
1111	rescreened by July 31, 2015.
1112	Section 27. Subsection (1) of section 408.811, Florida
1113	Statutes, is amended to read:
1114	408.811 Right of inspection; copies; inspection reports;
1115	plan for correction of deficiencies
1116	(1) An authorized officer or employee of the agency may
1117	make or cause to be made any inspection or investigation deemed
1118	necessary by the agency to determine the state of compliance
1119	with this part, authorizing statutes, and applicable rules. The
1120	right of inspection extends to any business that the agency has
1121	reason to believe is being operated as a provider without a
1122	license, but inspection of any business suspected of being
1123	operated without the appropriate license may not be made without
1124	the permission of the owner or person in charge unless a warrant
1125	is first obtained from a circuit court. Any application for a
1126	license issued under this part, authorizing statutes, or
1127	applicable rules constitutes permission for an appropriate
1128	inspection to verify the information submitted on or in
1129	connection with the application.
1130	(a) All inspections shall be unannounced, except as
1131	specified in s. 408.806.
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compliance.	1190	department, or Department of Health.
Section 28. Subsection (24) of section 408.820, Florida	1191	(2) An entity subject to this part may temporarily exceed
Statutes, is amended to read:		its licensed capacity to act as a receiving provider in
408.820 ExemptionsExcept as prescribed in authorizing	1193	accordance with an approved comprehensive emergency management
statutes, the following exemptions shall apply to specified	1194	<del>operations</del> plan for up to 15 days. While in an overcapacity
requirements of this part:		status, each provider must furnish or arrange for appropriate
(24) Multiphasic health testing centers, as provided under	1195	care and services to all clients. In addition, the agency may
part I of chapter 483, are exempt from s. 408.810(5)-(10).	1197	approve requests for overcapacity in excess of 15 days, which
Section 29. Subsections (1) and (2) of section 408.821,	1198	approvals may be based upon satisfactory justification and need
Florida Statutes, are amended to read:		as provided by the receiving and sending providers.
408.821 Emergency management planning; emergency	1200	Section 30. Subsection (3) of section 408.831, Florida
operations; inactive license		Statutes, is amended to read:
(1) A licensee required by authorizing statutes and agency	1202	408.831 Denial, suspension, or revocation of a license,
rule to have a comprehensive an emergency management operations	1203	registration, certificate, or application
plan must designate a safety liaison to serve as the primary		(3) This section provides standards of enforcement
contact for emergency operations. Such licensee shall submit its	1205	applicable to all entities licensed or regulated by the Agency
comprehensive emergency management plan to the local emergency	1206	for Health Care Administration. This section controls over any
management agency, county health department, or Department of	1207	conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
Health as follows:		400, 408, 429, 468, <del>483,</del> and 765 or rules adopted pursuant to
(a) Submit the plan within 30 days after initial licensure	1209	those chapters.
and change of ownership, and notify the agency within 30 days	1210	Section 31. Section 408.832, Florida Statutes, is amended
after submission of the plan.		to read:
(b) Submit the plan annually and within 30 days after any	1212	408.832 ConflictsIn case of conflict between the
significant modification, as defined by agency rule, to a	1213	provisions of this part and the authorizing statutes governing
previously approved plan.	1214	the licensure of health care providers by the Agency for Health
(c) Respond with necessary plan revisions within 30 days	1215	Care Administration found in s. 112.0455 and chapters 383, 390,
after notification that plan revisions are required.	1216	394, 395, 400, 429, 440, $\frac{483}{7}$ and 765, the provisions of this
(d) Notify the agency within 30 days after approval of its		part shall prevail.
plan by the local emergency management agency, county health	1218	Section 32. Subsection (9) of section 408.909, Florida
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Statutes, is amended to read:		1248	eligible on the dates on which the services were provided. Any
408.909 Health flex plans		1249	service under this section shall be provided only when medically
(9) PROGRAM EVALUATIONThe agency and the office shall		1250	necessary and in accordance with state and federal law.
evaluate the pilot program and its effect on the entities that		1251	Mandatory services rendered by providers in mobile units to
seek approval as health flex plans, on the number of enrollees,		1252	Medicaid recipients may be restricted by the agency. Nothing in
and on the scope of the health care coverage offered under a		1253	this section shall be construed to prevent or limit the agency
health flex plan; shall provide an assessment of the health flex		1254	from adjusting fees, reimbursement rates, lengths of stay,
plans and their potential applicability in other settings; shall		1255	number of visits, number of services, or any other adjustments
use health flex plans to gather more information to evaluate		1256	necessary to comply with the availability of moneys and any
low-income consumer driven benefit packages; and shall, by		1257	limitations or directions provided for in the General
January 15, 2016, and annually thereafter, jointly submit a		1258	Appropriations Act or chapter 216.
report to the Governor, the President of the Senate, and the		1259	(5) HOSPITAL INPATIENT SERVICESThe agency shall pay for
Speaker of the House of Representatives.		1260	all covered services provided for the medical care and treatment
Section 33. Paragraph (d) of subsection (10) of section		1261	of a recipient who is admitted as an inpatient by a licensed
408.9091, Florida Statutes, is amended to read:		1262	physician or dentist to a hospital licensed under part I of
408.9091 Cover Florida Health Care Access Program		1263	chapter 395. However, the agency shall limit the payment for
(10) PROGRAM EVALUATIONThe agency and the office shall:		1264	inpatient hospital services for a Medicaid recipient 21 years of
(d) Jointly submit by March 1, annually, a report to the		1265	age or older to 45 days or the number of days necessary to
Governor, the President of the Senate, and the Speaker of the		1266	comply with the General Appropriations Act.
House of Representatives which provides the information		1267	(a) 1. The agency may implement reimbursement and
specified in paragraphs (a)-(c) and recommendations relating to		1268	utilization management reforms in order to comply with any
the successful implementation and administration of the program.		1269	limitations or directions in the General Appropriations Act,
Section 34. Effective upon becoming a law, paragraph (a) of		1270	which may include, but are not limited to: prior authorization
subsection (5) of section 409.905, Florida Statutes, is amended		1271	for inpatient psychiatric days; prior authorization for
to read:		1272	nonemergency hospital inpatient admissions for individuals 21
409.905 Mandatory Medicaid servicesThe agency may make		1273	years of age and older; authorization of emergency and urgent-
payments for the following services, which are required of the		1274	care admissions within 24 hours after admission; enhanced
state by Title XIX of the Social Security Act, furnished by		1275	utilization and concurrent review programs for highly utilized
Medicaid providers to recipients who are determined to be		1276	services; reduction or elimination of covered days of service;
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1277	adjusting reimbursement ceilings for variable costs; adjusting	1306	
1278	reimbursement ceilings for fixed and property costs; and	1307	and local law, and who agrees that no person shall, on the
1279	implementing target rates of increase.	1308	grounds of handicap, race, color, or national origin, or for any
1280	2. The agency may limit prior authorization for hospital	1309	other reason, be subjected to discrimination under any program
1281	inpatient services to selected diagnosis-related groups, based	1310	or activity for which the provider receives payment from the
1282	on an analysis of the cost and potential for unnecessary	1311	agency.
1283	hospitalizations represented by certain diagnoses. Admissions	1312	(8) (a) A level 2 background screening pursuant to chapter
1284	for normal delivery and newborns are exempt from requirements	1313	435 must be conducted through the agency on each of the
1285	for prior authorization.	1314	following:
1286	3. In implementing the provisions of this section related	1315	1. The <del>Each</del> provider, or each principal of the provider if
1287	to prior authorization, the agency shall ensure that the process	1316	the provider is a corporation, partnership, association, or
1288	for authorization is accessible 24 hours per day, 7 days per	1317	other entity <del>, seeking to participate in the Medicaid program</del>
1289	week and authorization is automatically granted when not denied	1318	must submit a complete set of his or her fingerprints to the
1290	within 4 hours after the request. Authorization procedures must	1319	agency for the purpose of conducting a criminal history record
1291	include steps for review of denials.	1320	check.
1292	4. Upon implementing the prior authorization program for	1321	2. Principals of the provider, who include any officer,
1293	hospital inpatient services, the agency shall discontinue its	1322	director, billing agent, managing employee, or affiliated
1294	hospital retrospective review program. However, this	1323	person, or any partner or shareholder who has an ownership
1295	subparagraph may not be construed to prevent the agency from	1324	interest equal to 5 percent or more in the provider. However,
1296	conducting retrospective reviews under s. 409.913.	1325	for a hospital licensed under chapter 395 or a nursing home
1297	Section 35. It is the intent of the Legislature that	1326	licensed under chapter 400, principals of the provider are those
1298	section 409.905(5)(a), Florida Statutes, as amended by this act,	1327	who meet the definition of a controlling interest under s.
1299	confirms and clarifies existing law.	1328	408.803. A director of a not-for-profit corporation or
1300	Section 36. Subsection (8) of section 409.907, Florida	1329	organization is not a principal for purposes of a background
1301	Statutes, is amended to read:	1330	investigation required by this section if the director: serves
1302	409.907 Medicaid provider agreementsThe agency may make	1331	solely in a voluntary capacity for the corporation or
1303	payments for medical assistance and related services rendered to	1332	organization, does not regularly take part in the day-to-day
1304	Medicaid recipients only to an individual or entity who has a	1333	operational decisions of the corporation or organization,
1305	provider agreement in effect with the agency, who is performing	1334	receives no remuneration from the not-for-profit corporation or
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1335	organization for his or her service on the board of directors,
1336	has no financial interest in the not-for-profit corporation or
1337	organization, and has no family members with a financial
1338	interest in the not-for-profit corporation or organization; and
L339	if the director submits an affidavit, under penalty of perjury,
1340	to this effect to the agency and the not-for-profit corporation
1341	or organization submits an affidavit, under penalty of perjury,
1342	to this effect to the agency as part of the corporation's or
1343	organization's Medicaid provider agreement application.
1344	3. Any person who participates or seeks to participate in
1345	the Florida Medicaid program by way of rendering services to
1346	Medicaid recipients or having direct access to Medicaid
1347	recipients, recipient living areas, or the financial, medical,
1348	or service records of a Medicaid recipient or who supervises the
349	delivery of goods or services to a Medicaid recipient. This
1350	subparagraph does not impose additional screening requirements
351	on any providers licensed under part II of chapter 408.
1352	(b) Notwithstanding paragraph (a) the above, the agency may
L353	require a background check for any person reasonably suspected
L354	by the agency to have been convicted of a crime.
1355	(c) (a) Paragraph (a) This subsection does not apply to:
1356	1. A unit of local government, except that requirements of
357	this subsection apply to nongovernmental providers and entities
1358	contracting with the local government to provide Medicaid
1359	services. The actual cost of the state and national criminal
L360	history record checks must be borne by the nongovernmental
L361	provider or entity; or
1362	2. Any business that derives more than 50 percent of its
1363	revenue from the sale of goods to the final consumer, and the
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1364	business or its controlling parent is required to file a form
1365	10-K or other similar statement with the Securities and Exchange
1366	Commission or has a net worth of \$50 million or more.
1367	(d) (b) Background screening shall be conducted in
1368	accordance with chapter 435 and s. 408.809. The cost of the
1369	state and national criminal record check shall be borne by the
1370	provider.
1371	Section 37. Section 409.913, Florida Statutes, is amended
1372	to read:
1373	409.913 Oversight of the integrity of the Medicaid
1374	programThe agency shall operate a program to oversee the
1375	activities of Florida Medicaid recipients, and providers and
1376	their representatives, to ensure that fraudulent and abusive
1377	behavior and neglect of recipients occur to the minimum extent
1378	possible, and to recover overpayments and impose sanctions as
1379	appropriate. Each <u>January 15</u> <del>January 1</del> , the agency and the
1380	Medicaid Fraud Control Unit of the Department of Legal Affairs
1381	shall submit <u>reports</u> <del>a joint report</del> to the Legislature
1382	documenting the effectiveness of the state's efforts to control
1383	Medicaid fraud and abuse and to recover Medicaid overpayments
1384	during the previous fiscal year. The report must describe the
1385	number of cases opened and investigated each year; the sources
1386	of the cases opened; the disposition of the cases closed each
1387	year; the amount of overpayments alleged in preliminary and
1388	final audit letters; the number and amount of fines or penalties
1389	imposed; any reductions in overpayment amounts negotiated in
1390	settlement agreements or by other means; the amount of final
1391	agency determinations of overpayments; the amount deducted from
1392	federal claiming as a result of overpayments; the amount of
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	1422	1. Provider practices that are inconsistent with generally
<b>b</b>	1423	accepted business or medical practices and that result in an
	1424	unnecessary cost to the Medicaid program or in reimbursement for
	1425	goods or services that are not medically necessary or that fail
	1426	to meet professionally recognized standards for health care.
	1427	2. Recipient practices that result in unnecessary cost to
	1428	the Medicaid program.
	1429	(b) "Complaint" means an allegation that fraud, abuse, or
	1430	an overpayment has occurred.
	1431	(c) "Fraud" means an intentional deception or
	1432	misrepresentation made by a person with the knowledge that the
	1433	deception results in unauthorized benefit to herself or himself
	1434	or another person. The term includes any act that constitutes
	1435	fraud under applicable federal or state law.
5	1436	(d) "Medical necessity" or "medically necessary" means any
	1437	goods or services necessary to palliate the effects of a
	1438	terminal condition, or to prevent, diagnose, correct, cure,
	1439	alleviate, or preclude deterioration of a condition that
	1440	threatens life, causes pain or suffering, or results in illness
	1441	or infirmity, which goods or services are provided in accordance
	1442	with generally accepted standards of medical practice. For
	1443	purposes of determining Medicaid reimbursement, the agency is
	1444	the final arbiter of medical necessity. Determinations of
	1445	medical necessity must be made by a licensed physician employed
	1446	by or under contract with the agency and must be based upon
	1447	information available at the time the goods or services are
	1448	provided.
	1449	(e) "Overpayment" includes any amount that is not
	1450	authorized to be paid by the Medicaid program whether paid as a
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588-02756-20 202017260 1393 overpayments recovered each year; the amount of cost of 1394 investigation recovered each year; the average length of time to 1395 collect from the time the case was opened until the overpayment 1396 is paid in full; the amount determined as uncollectible and the 1397 portion of the uncollectible amount subsequently reclaimed from 1398 the Federal Government; the number of providers, by type, that 1399 are terminated from participation in the Medicaid program as a 1400 result of fraud and abuse; and all costs associated with 1401 discovering and prosecuting cases of Medicaid overpayments and 1402 making recoveries in such cases. The report must also document 1403 actions taken to prevent overpayments and the number of 1404 providers prevented from enrolling in or reenrolling in the 1405 Medicaid program as a result of documented Medicaid fraud and 1406 abuse and must include policy recommendations necessary to 1407 prevent or recover overpayments and changes necessary to prevent 1408 and detect Medicaid fraud. All policy recommendations in the 1409 report must include a detailed fiscal analysis, including, but 1410 not limited to, implementation costs, estimated savings to the 1411 Medicaid program, and the return on investment. The agency must 1412 submit the policy recommendations and fiscal analyses in the 1413 report to the appropriate estimating conference, pursuant to s. 1414 216.137, by February 15 of each year. The agency and the 1415 Medicaid Fraud Control Unit of the Department of Legal Affairs 1416 each must include detailed unit-specific performance standards, 1417 benchmarks, and metrics in the report, including projected cost 1418 savings to the state Medicaid program during the following 1419 fiscal year. 1420 (1) For the purposes of this section, the term: 1421 (a) "Abuse" means: Page 49 of 81

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1451	result of inaccurate or improper cost reporting, improper
1452	claiming, unacceptable practices, fraud, abuse, or mistake.
1453	(f) "Person" means any natural person, corporation,
1454	partnership, association, clinic, group, or other entity,
1455	whether or not such person is enrolled in the Medicaid program
1456	or is a provider of health care.
1457	(2) The agency shall conduct, or cause to be conducted by
1458	contract or otherwise, reviews, investigations, analyses,
1459	audits, or any combination thereof, to determine possible fraud,
1460	abuse, overpayment, or recipient neglect in the Medicaid program
1461	and shall report the findings of any overpayments in audit
1462	reports as appropriate. At least 5 percent of all audits shall
1463	be conducted on a random basis. As part of its ongoing fraud
1464	detection activities, the agency shall identify and monitor, by
1465	contract or otherwise, patterns of overutilization of Medicaid
1466	services based on state averages. The agency shall track
1467	Medicaid provider prescription and billing patterns and evaluate
1468	them against Medicaid medical necessity criteria and coverage
1469	and limitation guidelines adopted by rule. Medical necessity
1470	determination requires that service be consistent with symptoms
1471	or confirmed diagnosis of illness or injury under treatment and
1472	not in excess of the patient's needs. The agency shall conduct
1473	reviews of provider exceptions to peer group norms and shall,
1474	using statistical methodologies, provider profiling, and
1475	analysis of billing patterns, detect and investigate abnormal or
1476	unusual increases in billing or payment of claims for Medicaid
1477	services and medically unnecessary provision of services.
1478	(3) The agency may conduct, or may contract for, prepayment
1479	review of provider claims to ensure cost-effective purchasing;
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1480	to ensure that billing by a provider to the agency is in
1481	accordance with applicable provisions of all Medicaid rules,
1482	regulations, handbooks, and policies and in accordance with
1483	federal, state, and local law; and to ensure that appropriate
1484	care is rendered to Medicaid recipients. Such prepayment reviews
1485	may be conducted as determined appropriate by the agency,
1486	without any suspicion or allegation of fraud, abuse, or neglect,
1487	and may last for up to 1 year. Unless the agency has reliable
1488	evidence of fraud, misrepresentation, abuse, or neglect, claims
1489	shall be adjudicated for denial or payment within 90 days after
1490	receipt of complete documentation by the agency for review. If
1491	there is reliable evidence of fraud, misrepresentation, abuse,
1492	or neglect, claims shall be adjudicated for denial of payment
1493	within 180 days after receipt of complete documentation by the
1494	agency for review.
1495	(4) Any suspected criminal violation identified by the
1496	agency must be referred to the Medicaid Fraud Control Unit of
1497	the Office of the Attorney General for investigation. The agency
1498	and the Attorney General shall enter into a memorandum of
1499	understanding, which must include, but need not be limited to, a
1500	protocol for regularly sharing information and coordinating
1501	casework. The protocol must establish a procedure for the
1502	referral by the agency of cases involving suspected Medicaid
1503	fraud to the Medicaid Fraud Control Unit for investigation, and
1504	the return to the agency of those cases where investigation
1505	determines that administrative action by the agency is
1506	appropriate. Offices of the Medicaid program integrity program
1507	and the Medicaid Fraud Control Unit of the Department of Legal
1508	Affairs, shall, to the extent possible, be collocated. The
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that:

588-02756-20 20201726c1 588-02756-20 20201726c1 agency and the Department of Legal Affairs shall periodically 1538 (b) Are Medicaid-covered goods or services that are conduct joint training and other joint activities designed to 1539 medically necessary. increase communication and coordination in recovering 1540 (c) Are of a quality comparable to those furnished to the 1541 general public by the provider's peers. overpayments. (5) A Medicaid provider is subject to having goods and 1542 (d) Have not been billed in whole or in part to a recipient services that are paid for by the Medicaid program reviewed by 1543 or a recipient's responsible party, except for such copayments, an appropriate peer-review organization designated by the 1544 coinsurance, or deductibles as are authorized by the agency. agency. The written findings of the applicable peer-review 1545 (e) Are provided in accord with applicable provisions of 1546 organization are admissible in any court or administrative all Medicaid rules, regulations, handbooks, and policies and in proceeding as evidence of medical necessity or the lack thereof. 1547 accordance with federal, state, and local law. (6) Any notice required to be given to a provider under 1548 (f) Are documented by records made at the time the goods or this section is presumed to be sufficient notice if sent to the 1549 services were provided, demonstrating the medical necessity for address last shown on the provider enrollment file. It is the 1550 the goods or services rendered. Medicaid goods or services are responsibility of the provider to furnish and keep the agency 1551 excessive or not medically necessary unless both the medical informed of the provider's current address. United States Postal 1552 basis and the specific need for them are fully and properly Service proof of mailing or certified or registered mailing of 1553 documented in the recipient's medical record. such notice to the provider at the address shown on the provider 1554 enrollment file constitutes sufficient proof of notice. Any 1555 The agency shall deny payment or require repayment for goods or notice required to be given to the agency by this section must 1556 services that are not presented as required in this subsection. be sent to the agency at an address designated by rule. 1557 (8) The agency shall not reimburse any person or entity for (7) When presenting a claim for payment under the Medicaid 1558 any prescription for medications, medical supplies, or medical program, a provider has an affirmative duty to supervise the 1559 services if the prescription was written by a physician or other provision of, and be responsible for, goods and services claimed 1560 prescribing practitioner who is not enrolled in the Medicaid to have been provided, to supervise and be responsible for 1561 program. This section does not apply: 1562 preparation and submission of the claim, and to present a claim (a) In instances involving bona fide emergency medical that is true and accurate and that is for goods and services 1563 conditions as determined by the agency; 1564 (b) To a provider of medical services to a patient in a (a) Have actually been furnished to the recipient by the 1565 hospital emergency department, hospital inpatient or outpatient provider prior to submitting the claim. setting, or nursing home; 1566 Page 53 of 81 Page 54 of 81 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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20201726c1 588-02756-20 20201726c1 (c) To bona fide pro bono services by preapproved non-1596 inappropriate, medically unnecessary, or excessive goods or Medicaid providers as determined by the agency; 1597 services from the person furnishing them, the person under whose (d) To prescribing physicians who are board-certified 1598 supervision they were furnished, or the person causing them to specialists treating Medicaid recipients referred for treatment 1599 be furnished. by a treating physician who is enrolled in the Medicaid program; 1600 (12) The complaint and all information obtained pursuant to (e) To prescriptions written for dually eligible Medicare 1601 an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation beneficiaries by an authorized Medicare provider who is not 1602 enrolled in the Medicaid program; 1603 of fraud, abuse, or neglect are confidential and exempt from the (f) To other physicians who are not enrolled in the 1604 provisions of s. 119.07(1): Medicaid program but who provide a medically necessary service 1605 (a) Until the agency takes final agency action with respect or prescription not otherwise reasonably available from a 1606 to the provider and requires repayment of any overpayment, or Medicaid-enrolled physician; or imposes an administrative sanction; 1607 (9) A Medicaid provider shall retain medical, professional, 1608 (b) Until the Attorney General refers the case for criminal financial, and business records pertaining to services and goods 1609 prosecution; furnished to a Medicaid recipient and billed to Medicaid for a 1610 (c) Until 10 days after the complaint is determined without period of 5 years after the date of furnishing such services or 1611 merit; or goods. The agency may investigate, review, or analyze such 1612 (d) At all times if the complaint or information is records, which must be made available during normal business 1613 otherwise protected by law. hours. However, 24-hour notice must be provided if patient 1614 (13) The agency shall terminate participation of a Medicaid treatment would be disrupted. The provider must keep the agency 1615 provider in the Medicaid program and may seek civil remedies or informed of the location of the provider's Medicaid-related 1616 impose other administrative sanctions against a Medicaid records. The authority of the agency to obtain Medicaid-related 1617 provider, if the provider or any principal, officer, director, records from a provider is neither curtailed nor limited during 1618 agent, managing employee, or affiliated person of the provider, a period of litigation between the agency and the provider. 1619 or any partner or shareholder having an ownership interest in (10) Payments for the services of billing agents or persons 1620 the provider equal to 5 percent or greater, has been convicted participating in the preparation of a Medicaid claim shall not 1621 of a criminal offense under federal law or the law of any state be based on amounts for which they bill nor based on the amount 1622 relating to the practice of the provider's profession, or a a provider receives from the Medicaid program. 1623 criminal offense listed under s. 408.809(4), s. 409.907(10), or (11) The agency shall deny payment or require repayment for 1624 s. 435.04(2). If the agency determines that the provider did not Page 55 of 81 Page 56 of 81 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

588-02756-20 20201726c1 1625 participate or acquiesce in the offense, termination will not be 1626 imposed. If the agency effects a termination under this 1627 subsection, the agency shall take final agency action. 1628 (14) If the provider has been suspended or terminated from 1629 participation in the Medicaid program or the Medicare program by 1630 the Federal Government or any state, the agency must immediately 1631 suspend or terminate, as appropriate, the provider's 1632 participation in this state's Medicaid program for a period no 1633 less than that imposed by the Federal Government or any other 1634 state, and may not enroll such provider in this state's Medicaid 1635 program while such foreign suspension or termination remains in 1636 effect. The agency shall also immediately suspend or terminate, 1637 as appropriate, a provider's participation in this state's 1638 Medicaid program if the provider participated or acquiesced in 1639 any action for which any principal, officer, director, agent, 1640 managing employee, or affiliated person of the provider, or any 1641 partner or shareholder having an ownership interest in the 1642 provider equal to 5 percent or greater, was suspended or 1643 terminated from participating in the Medicaid program or the 1644 Medicare program by the Federal Government or any state. This 1645 sanction is in addition to all other remedies provided by law. 1646 (15) The agency shall seek a remedy provided by law, 1647 including, but not limited to, any remedy provided in 1648 subsections (13) and (16) and s. 812.035, if: 1649 (a) The provider's license has not been renewed, or has 1650 been revoked, suspended, or terminated, for cause, by the 1651 licensing agency of any state; 1652 (b) The provider has failed to make available or has 1653 refused access to Medicaid-related records to an auditor, Page 57 of 81

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588-02756-20 20201726c1 1654 investigator, or other authorized employee or agent of the 1655 agency, the Attorney General, a state attorney, or the Federal 1656 Government; 1657 (c) The provider has not furnished or has failed to make 1658 available such Medicaid-related records as the agency has found 1659 necessary to determine whether Medicaid payments are or were due 1660 and the amounts thereof; 1661 (d) The provider has failed to maintain medical records 1662 made at the time of service, or prior to service if prior 1663 authorization is required, demonstrating the necessity and 1664 appropriateness of the goods or services rendered; 1665 (e) The provider is not in compliance with provisions of 1666 Medicaid provider publications that have been adopted by 1667 reference as rules in the Florida Administrative Code; with 1668 provisions of state or federal laws, rules, or regulations; with 1669 provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on 1670 1671 transmittal forms for electronically submitted claims that are 1672 submitted by the provider or authorized representative, as such 1673 provisions apply to the Medicaid program; 1674 (f) The provider or person who ordered, authorized, or 1675 prescribed the care, services, or supplies has furnished, or 1676 ordered or authorized the furnishing of, goods or services to a 1677 recipient which are inappropriate, unnecessary, excessive, or 1678 harmful to the recipient or are of inferior quality; 1679 (g) The provider has demonstrated a pattern of failure to 1680 provide goods or services that are medically necessary; 1681 (h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the 1682

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goods or services, has submitted or caused to be submitted false	1712	(n) The provider fails to demonstrate that it had available
or a pattern of erroneous Medicaid claims;	1713	during a specific audit or review period sufficient quantities
(i) The provider or an authorized representative of the	1714	of goods, or sufficient time in the case of services, to support
provider, or a person who has ordered, authorized, or prescribed	1715	the provider's billings to the Medicaid program;
the goods or services, has submitted or caused to be submitted a	1716	(o) The provider has failed to comply with the notice and
Medicaid provider enrollment application, a request for prior	1717	reporting requirements of s. 409.907;
authorization for Medicaid services, a drug exception request,	1718	(p) The agency has received reliable information of patient
or a Medicaid cost report that contains materially false or	1719	abuse or neglect or of any act prohibited by s. 409.920; or
incorrect information;	1720	(q) The provider has failed to comply with an agreed-upon
(j) The provider or an authorized representative of the	1721	repayment schedule.
provider has collected from or billed a recipient or a	1722	
recipient's responsible party improperly for amounts that should	1723	A provider is subject to sanctions for violations of this
not have been so collected or billed by reason of the provider's	1724	subsection as the result of actions or inactions of the
billing the Medicaid program for the same service;	1725	provider, or actions or inactions of any principal, officer,
(k) The provider or an authorized representative of the	1726	director, agent, managing employee, or affiliated person of the
provider has included in a cost report costs that are not	1727	provider, or any partner or shareholder having an ownership
allowable under a Florida Title XIX reimbursement plan after the	1728	interest in the provider equal to 5 percent or greater, in which
provider or authorized representative had been advised in an	1729	the provider participated or acquiesced.
audit exit conference or audit report that the costs were not	1730	(16) The agency shall impose any of the following sanctions
allowable;	1731	or disincentives on a provider or a person for any of the acts
(1) The provider is charged by information or indictment	1732	described in subsection (15):
with fraudulent billing practices or an offense referenced in	1733	(a) Suspension for a specific period of time of not more
subsection (13). The sanction applied for this reason is limited	1734	than 1 year. Suspension precludes participation in the Medicaid
to suspension of the provider's participation in the Medicaid	1735	program, which includes any action that results in a claim for
program for the duration of the indictment unless the provider	1736	payment to the Medicaid program for furnishing, supervising a
is found guilty pursuant to the information or indictment;	1737	person who is furnishing, or causing a person to furnish goods
(m) The provider or a person who ordered, authorized, or	1738	or services.
prescribed the goods or services is found liable for negligent	1739	(b) Termination for a specific period of time ranging from
practice resulting in death or injury to the provider's patient;	1740	more than 1 year to 20 years. Termination precludes
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person to furnish goods or services.

Medicaid cost report after the provider or authorized

to a provider is considered a separate violation.

immediate final order under s. 120.569(2)(n).

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paragraph (15)(i).

20201726c1 588-02756-20 20201726c1 participation in the Medicaid program, which includes any action 1770 (f) Imposition of liens against provider assets, including, that results in a claim for payment to the Medicaid program for 1771 but not limited to, financial assets and real property, not to furnishing, supervising a person who is furnishing, or causing a 1772 exceed the amount of fines or recoveries sought, upon entry of 1773 an order determining that such moneys are due or recoverable. (g) Prepayment reviews of claims for a specified period of (c) Imposition of a fine of up to \$5,000 for each 1774 violation. Each day that an ongoing violation continues, such as 1775 time. 1776 refusing to furnish Medicaid-related records or refusing access (h) Comprehensive followup reviews of providers every 6 to records, is considered a separate violation. Each instance of 1777 months to ensure that they are billing Medicaid correctly. 1778 (i) Corrective-action plans that remain in effect for up to improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home 1779 3 years and that are monitored by the agency every 6 months 1780 while in effect. representative has been advised in an audit exit conference or 1781 (i) Other remedies as permitted by law to effect the previous audit report of the cost unallowability; each instance recovery of a fine or overpayment. 1782 of furnishing a Medicaid recipient goods or professional 1783 services that are inappropriate or of inferior guality as 1784 If a provider voluntarily relinguishes its Medicaid provider 1785 number or an associated license, or allows the associated determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid 1786 licensure to expire after receiving written notice that the 1787 agency is conducting, or has conducted, an audit, survey, provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; 1788 inspection, or investigation and that a sanction of suspension each instance of inappropriate prescribing of drugs for a 1789 or termination will or would be imposed for noncompliance Medicaid recipient as determined by competent peer judgment; and 1790 discovered as a result of the audit, survey, inspection, or each false or erroneous Medicaid claim leading to an overpayment 1791 investigation, the agency shall impose the sanction of 1792 termination for cause against the provider. The agency's (d) Immediate suspension, if the agency has received 1793 termination with cause is subject to hearing rights as may be 1794 information of patient abuse or neglect or of any act prohibited provided under chapter 120. The Secretary of Health Care by s. 409.920. Upon suspension, the agency must issue an 1795 Administration may make a determination that imposition of a 1796 sanction or disincentive is not in the best interest of the (e) A fine, not to exceed \$10,000, for a violation of 1797 Medicaid program, in which case a sanction or disincentive may 1798 not be imposed. Page 62 of 81

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1799	(17) In determining the appropriate administrative sanction			1828	against an entire group.	
1800	to be applied, or the duration of any suspension or termination,			1829	(19) The agency shall establish a	1 5
1801	the agency shall consider:			1830	followup reviews of a sampling of prov	
1802	(a) The seriousness and extent of the violation or			1831	of overpayment under the Medicaid prog	-
1803	violations.			1832	consider the magnitude of previous fram	
1804	(b) Any prior history of violations by the provider			1833	potential effect of continued fraud or	abuse on Medicaid costs.
1805	relating to the delivery of health care programs which resulted			1834	(20) In making a determination of	overpayment to a
1806	in either a criminal conviction or in administrative sanction or			1835	provider, the agency must use accepted	and valid auditing,
1807	penalty.			1836	accounting, analytical, statistical, or	r peer-review methods, or
1808	(c) Evidence of continued violation within the provider's			1837	combinations thereof. Appropriate stat:	istical methods may
1809	management control of Medicaid statutes, rules, regulations, or			1838	include, but are not limited to, sample	ing and extension to the
1810	policies after written notification to the provider of improper			1839	population, parametric and nonparametri	ic statistics, tests of
1811	practice or instance of violation.			1840	hypotheses, and other generally accepted	ed statistical methods.
1812	(d) The effect, if any, on the quality of medical care			1841	Appropriate analytical methods may inc.	lude, but are not limited
1813	provided to Medicaid recipients as a result of the acts of the			1842	to, reviews to determine variances betw	ween the quantities of
1814	provider.			1843	products that a provider had on hand an	nd available to be
1815	(e) Any action by a licensing agency respecting the			1844	purveyed to Medicaid recipients during	the review period and the
1816	provider in any state in which the provider operates or has			1845	quantities of the same products paid for	or by the Medicaid program
1817	operated.			1846	for the same period, taking into approp	priate consideration sales
1818	(f) The apparent impact on access by recipients to Medicaid			1847	of the same products to non-Medicaid c	ustomers during the same
1819	services if the provider is suspended or terminated, in the best			1848	period. In meeting its burden of proof	in any administrative or
1820	judgment of the agency.			1849	court proceeding, the agency may intro	duce the results of such
1821				1850	statistical methods as evidence of over	rpayment.
1822	The agency shall document the basis for all sanctioning actions			1851	(21) When making a determination	that an overpayment has
1823	and recommendations.			1852	occurred, the agency shall prepare and	issue an audit report to
1824	(18) The agency may take action to sanction, suspend, or			1853	the provider showing the calculation of	f overpayments. The
1825	terminate a particular provider working for a group provider,			1854	agency's determination must be based so	olely upon information
1826	and may suspend or terminate Medicaid participation at a			1855	available to it before issuance of the	audit report and, in the
1827	specific location, rather than or in addition to taking action			1856	case of documentation obtained to subs	tantiate claims for
·	Page 63 of 81			·	Page 64 of 83	1
с	<b>ODING:</b> Words stricken are deletions; words <u>underlined</u> are additions.	S. CODING: Words stricken are deletions; words <u>underlined</u> are			rds <u>underlined</u> are additions.	

20201726c1 588-02756-20 1857 Medicaid reimbursement, based solely upon contemporaneous 1858 records. The agency may consider addenda or modifications to a 1859 note that was made contemporaneously with the patient care 1860 episode if the addenda or modifications are germane to the note. 1861 (22) The audit report, supported by agency work papers, 1862 showing an overpayment to a provider constitutes evidence of the 1863 overpayment. A provider may not present or elicit testimony on 1864 direct examination or cross-examination in any court or 1865 administrative proceeding, regarding the purchase or acquisition 1866 by any means of drugs, goods, or supplies; sales or divestment 1867 by any means of drugs, goods, or supplies; or inventory of 1868 drugs, goods, or supplies, unless such acquisition, sales, 1869 divestment, or inventory is documented by written invoices, 1870 written inventory records, or other competent written 1871 documentary evidence maintained in the normal course of the 1872 provider's business. A provider may not present records to 1873 contest an overpayment or sanction unless such records are 1874 contemporaneous and, if requested during the audit process, were 1875 furnished to the agency or its agent upon request. This 1876 limitation does not apply to Medicaid cost report audits. This 1877 limitation does not preclude consideration by the agency of 1878 addenda or modifications to a note if the addenda or 1879 modifications are made before notification of the audit, the 1880 addenda or modifications are germane to the note, and the note 1881 was made contemporaneously with a patient care episode. 1882 Notwithstanding the applicable rules of discovery, all 1883 documentation to be offered as evidence at an administrative 1884 hearing on a Medicaid overpayment or an administrative sanction 1885 must be exchanged by all parties at least 14 days before the Page 65 of 81

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1886	administrative hearing or be excluded from consideration.
1887	(23)(a) In an audit <u>, <del>or</del> investigation, or enforcement</u>
1888	action taken for $\frac{1}{2}$ a violation committed by a provider which is
1889	conducted pursuant to this section, the agency is entitled to
1890	recover all investigative and $_{ au}$ legal costs incurred as a result
1891	of such audit, investigation, or enforcement action. The costs
1892	associated with an investigation, audit, or enforcement action
1893	may include, but are not limited to, salaries and benefits of
1894	personnel, costs related to the time spent by an attorney and
1895	other personnel working on the case, and any other expenses
1896	incurred by the agency or contractor which are associated with
1897	the case, including any, and expert witness costs and attorney
1898	fees incurred on behalf of the agency or contractor if the
1899	agency's findings were not contested by the provider or, if
1900	contested, the agency ultimately prevailed.
1901	(b) The agency has the burden of documenting the costs,
1902	which include salaries and employee benefits and out-of-pocket
1903	expenses. The amount of costs that may be recovered must be
1904	reasonable in relation to the seriousness of the violation and
1905	must be set taking into consideration the financial resources,
1906	earning ability, and needs of the provider, who has the burden
1907	of demonstrating such factors.
1908	(c) The provider may pay the costs over a period to be
1909	determined by the agency if the agency determines that an
1910	extreme hardship would result to the provider from immediate
1911	full payment. Any default in payment of costs may be collected
1912	by any means authorized by law.
1913	(24) If the agency imposes an administrative sanction
1914	pursuant to subsection $(13)$ , subsection $(14)$ , or subsection
I	Page 66 of 81
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(15), except paragraphs (15) (e) and (o), upon any provider or	1944	(d) The agency, upon entry of a final agency order, a
any principal, officer, director, agent, managing employee, or	1945	judgment or order of a court of competent jurisdiction, or a
affiliated person of the provider who is regulated by another	1946	stipulation or settlement, may collect the moneys owed by all
state entity, the agency shall notify that other entity of the	1947	means allowable by law, including, but not limited to, notifying
imposition of the sanction within 5 business days. Such	1948	any fiscal intermediary of Medicare benefits that the state has
notification must include the provider's or person's name and	1940	a superior right of payment. Upon receipt of such written
license number and the specific reasons for sanction.	1949	notification, the Medicare fiscal intermediary shall remit to
-	1950	the state the sum claimed.
(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable	1951	(e) The agency may institute amnesty programs to allow
evidence that the circumstances giving rise to the need for a		Medicaid providers the opportunity to voluntarily repay
	1953	
withholding of payments involve fraud, willful	1954	overpayments. The agency may adopt rules to administer such
misrepresentation, or abuse under the Medicaid program, or a	1955	programs.
crime committed while rendering goods or services to Medicaid	1956	(26) The agency may impose administrative sanctions against
recipients. If it is determined that fraud, willful	1957	a Medicaid recipient, or the agency may seek any other remedy
misrepresentation, abuse, or a crime did not occur, the payments	1958	provided by law, including, but not limited to, the remedies
withheld must be paid to the provider within 14 days after such	1959	provided in s. 812.035, if the agency finds that a recipient has
determination. Amounts not paid within 14 days accrue interest	1960	engaged in solicitation in violation of s. 409.920 or that the
at the rate of 10 percent per year, beginning after the 14th	1961	recipient has otherwise abused the Medicaid program.
day.	1962	(27) When the Agency for Health Care Administration has
(b) The agency shall deny payment, or require repayment, if	1963	made a probable cause determination and alleged that an
the goods or services were furnished, supervised, or caused to	1964	overpayment to a Medicaid provider has occurred, the agency,
be furnished by a person who has been suspended or terminated	1965	after notice to the provider, shall:
from the Medicaid program or Medicare program by the Federal	1966	(a) Withhold, and continue to withhold during the pendency
Government or any state.	1967	of an administrative hearing pursuant to chapter 120, any
(c) Overpayments owed to the agency bear interest at the	1968	medical assistance reimbursement payments until such time as the
rate of 10 percent per year from the date of final determination	1969	overpayment is recovered, unless within 30 days after receiving
of the overpayment by the agency, and payment arrangements must	1970	notice thereof the provider:
be made within 30 days after the date of the final order, which	1971	1. Makes repayment in full; or
is not subject to further appeal.	1972	2. Establishes a repayment plan that is satisfactory to the
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CS for SB 1726

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stration.	2002	plan or settlement agreement, the agency shall withhold				
e to withhold during the pendency	2003	reimbursement payments for Medicaid services until the amount				
oursuant to chapter 120, medical	2004	due is paid in full.				
ents if the terms of a repayment	2005	(32) Duly authorized agents and employees of the agency				
e provider.	2006	shall have the power to inspect, during normal business hours,				
aid program integrity cases lies in	2007	the records of any pharmacy, wholesale establishment, or				
n of the agency.	2008	manufacturer, or any other place in which drugs and medical				
er provisions of law, the agency	2009	supplies are manufactured, packed, packaged, made, stored, sold,				
Unit of the Department of Legal	2010	or kept for sale, for the purpose of verifying the amount of				
s Medicaid-related and non-	2011	drugs and medical supplies ordered, delivered, or purchased by a				
der to determine the total output	2012	provider. The agency shall provide at least 2 business days'				
econcile quantities of goods or	2013	prior notice of any such inspection. The notice must identify				
th quantities of goods or services	2014	the provider whose records will be inspected, and the inspection				
practice.	2015	shall include only records specifically related to that				
minate a provider's participation	2016	provider.				
e provider fails to reimburse an	2017	(33) In accordance with federal law, Medicaid recipients				
mposed fine that has been	2018	convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be				
subject to further appeal, within	2019	limited, restricted, or suspended from Medicaid eligibility for				
final order, unless the provider	2020	a period not to exceed 1 year, as determined by the agency head				
nto a repayment agreement.	2021	or designee.				
sts an administrative hearing	2022	(34) To deter fraud and abuse in the Medicaid program, the				
hearing must be conducted within	2023	agency may limit the number of Schedule II and Schedule III				
of an administrative law judge,	2024	refill prescription claims submitted from a pharmacy provider.				
se shown as determined by the	2025	The agency shall limit the allowable amount of reimbursement of				
earing officer. Upon issuance of a	2026	prescription refill claims for Schedule II and Schedule III				
palance of the amount determined to	2027	pharmaceuticals if the agency or the Medicaid Fraud Control Unit				
d fines is due. If a provider fails	2028	determines that the specific prescription refill was not				
s to enter into a satisfactory	2029	requested by the Medicaid recipient or authorized representative				
omply with the terms of a repayment	2030	for whom the refill claim is submitted or was not prescribed by				
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tions; words underlined are additions.	CODING: Words stricken are deletions; words underlined are additi					
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1973 Agency for Health Care Administ

1974 (b) Withhold, and continue 1975 of an administrative hearing pu assistance reimbursement paymen 1976 1977 plan are not adhered to by the

1978 (28) Venue for all Medicai 1979 Leon County, at the discretion

1980 (29) Notwithstanding other 1981 and the Medicaid Fraud Control 1982 Affairs may review a provider's 1983 Medicaid-related records in ord 1984 of a provider's practice to rec 1985 services billed to Medicaid wit 1986 used in the provider's total pr

1987 (30) The agency shall term 1988 in the Medicaid program if the 1989 overpayment or pay an agency-im 1990 determined by final order, not 1991 30 days after the date of the f 1992 and the agency have entered int

1993 (31) If a provider request pursuant to chapter 120, such h 1994 1995 90 days following assignment of

1996 absent exceptionally good cause

1997 administrative law judge or hea

- 1998 final order, the outstanding ba
- 1999 constitute the overpayment and
- 2000 to make payments in full, fails
- 2001 repayment plan, or fails to com

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20201726c1 588-02756-20 20201726c1 the recipient's medical provider or physician. Any such refill 2060 formatted lists that may be printed or imported into other request must be consistent with the original prescription. 2061 applications, including spreadsheets. The agency shall update (35) The Office of Program Policy Analysis and Government 2062 the list at least monthly. Accountability shall provide a report to the President of the 2063 (38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize Senate and the Speaker of the House of Representatives on a 2064 biennial basis, beginning January 31, 2006, on the agency's 2065 the electronic exchange of health care fraud information, the efforts to prevent, detect, and deter, as well as recover funds 2066 agency shall: lost to, fraud and abuse in the Medicaid program. 2067 (a) Compile, maintain, and publish on its website a 2068 detailed list of all state and federal databases that contain (36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of 2069 health care fraud information and update the list at least explanations of benefits information about services reimbursed 2070 biannually; 2071 by the Medicaid program for goods and services to such (b) Develop a strategic plan to connect all databases that recipients, including information on how to report inappropriate 2072 contain health care fraud information to facilitate the or incorrect billing to the agency or other law enforcement 2073 electronic exchange of health information between the agency, entities for review or investigation, information on how to 2074 the Department of Health, the Department of Law Enforcement, and report criminal Medicaid fraud to the Medicaid Fraud Control 2075 the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and Unit's toll-free hotline number, and information about the 2076 rewards available under s. 409.9203. The explanation of benefits 2077 specifications for the technical interface between state and may not be mailed for Medicaid independent laboratory services 2078 federal health care fraud databases; as described in s. 409.905(7) or for Medicaid certified match 2079 (c) Monitor innovations in health information technology, services as described in ss. 409.9071 and 1011.70. 2080 specifically as it pertains to Medicaid fraud prevention and (37) The agency shall post on its website a current list of 2081 detection; and each Medicaid provider, including any principal, officer, 2082 (d) Periodically publish policy briefs that highlight director, agent, managing employee, or affiliated person of the 2083 available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or provider, or any partner or shareholder having an ownership 2084 the Federal Government which use technology to prevent or detect interest in the provider equal to 5 percent or greater, who has 2085 been terminated for cause from the Medicaid program or 2086 health care fraud. sanctioned under this section. The list must be searchable by a 2087 Section 38. Subsection (1) of section 409.967, Florida variety of search parameters and provide for the creation of Statutes, is amended to read: 2088 Page 72 of 81

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409.967 Managed care plan accountability	-	2	118	shall be disseminated, at no charge, to the Department of
(1) Beginning with the contract procuremer	it process	2	119	Elderly Affairs, the Department of Health, the Department of
initiated during the 2023 calendar year, the ac	Jency shall	2	120	Children and Families, the Agency for Persons with Disabilities,
establish a <u>6-year</u> <del>5-year</del> contract with each ma	naged care plan	2	121	the area agencies on aging, the Florida Statewide Advocacy
selected through the procurement process descri	.bed in s.	2	122	Council, the State Long-Term Care Ombudsman Program, and state
409.966. A plan contract may not be renewed; ho	wever, the agency	2	123	and local ombudsman councils. The Department of Children and
may extend the term of a plan contract to cover	any delays	2	124	Families shall disseminate the list to service providers under
during the transition to a new plan. The agency	/ shall extend	2	125	contract to the department who are responsible for referring
until December 31, 2024, the term of existing p	lan contracts	2	126	persons to a facility for residency. The agency may charge a fee
awarded pursuant to the invitation to negotiate	published in	2	127	commensurate with the cost of printing and postage to other
July 2017.		2	128	interested parties requesting a copy of this list. This
Section 39. Subsection (6) of section 429.	11, Florida	2	129	information may be provided electronically or through the
Statutes, is amended to read:		2	130	agency's Internet site.
429.11 Initial application for license; pr	ovisional	2	131	Section 41. Subsection (2) of section 429.35, Florida
license		2	132	Statutes, is amended to read:
(6) In addition to the license categories	available in s.	2	133	429.35 Maintenance of records; reports
408.808, a provisional license may be issued to	- an applicant	2	134	(2) Within 60 days after the date of <u>an</u> the biennial
making initial application for licensure or mak	ing application	2	135	inspection conducted visit required under s. 408.811 or within
for a change of ownership. A provisional licens	<del>e shall be</del>	2	136	30 days after the date of $\underline{an} any$ interim visit, the agency shall
limited in duration to a specific period of tim	e not to exceed 6	2	137	forward the results of the inspection to the local ombudsman
months, as determined by the agency.		2	138	council in the district where the facility is located; to at
Section 40. Subsection (9) of section 429.	19, Florida	2	139	least one public library or, in the absence of a public library,
Statutes, is amended to read:		2	140	the county seat in the county in which the inspected assisted
429.19 Violations; imposition of administr	ative fines;	2	141	living facility is located; and, when appropriate, to the
grounds		2	142	district Adult Services and Mental Health Program Offices.
(9) The agency shall develop and dissemina	te an annual list	2	143	Section 42. Subsection (2) of section 429.905, Florida
of all facilities sanctioned or fined for viola	tions of state	2	144	Statutes, is amended to read:
standards, the number and class of violations i	.nvolved, the	2	145	429.905 Exemptions; monitoring of adult day care center
penalties imposed, and the current status of ca	ses. The list	2	146	programs colocated with assisted living facilities or licensed
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nursing home facilities .-

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to read:

relate to:

20201726c1 588-02756-20 20201726c1 2176 number of participants. (2) A licensed assisted living facility, a licensed 2177 (2) (b) The number and gualifications of all personnel hospital, or a licensed nursing home facility may provide 2178 employed by adult day care centers who have responsibilities for services during the day which include, but are not limited to, 2179 the care of participants. social, health, therapeutic, recreational, nutritional, and 2180 (3) (c) All sanitary conditions within adult day care respite services, to adults who are not residents. Such a 2181 centers and their surroundings, including water supply, sewage disposal, food handling, and general hygiene, and maintenance of facility need not be licensed as an adult day care center; 2182 however, the agency must monitor the facility during the regular 2183 sanitary conditions, to ensure the health and comfort of inspection and at least biennially to ensure adequate space and 2184 participants. sufficient staff. If an assisted living facility, a hospital, or 2185 (4) (d) Basic services provided by adult day care centers. a nursing home holds itself out to the public as an adult day 2186 (5) (c) Supportive and optional services provided by adult care center, it must be licensed as such and meet all standards 2187 day care centers. prescribed by statute and rule. For the purpose of this 2188 (6) (f) Data and information relative to participants and subsection, the term "day" means any portion of a 24-hour day. 2189 programs of adult day care centers, including, but not limited Section 43. Section 429.929, Florida Statutes, is amended 2190 to, the physical and mental capabilities and needs of the 2191 participants, the availability, frequency, and intensity of 429.929 Rules establishing standards.basic services and of supportive and optional services provided, 2192 (1) The agency shall adopt rules to implement this part. 2193 the frequency of participation, the distances traveled by The rules must include reasonable and fair standards. Any 2194 participants, the hours of operation, the number of referrals to conflict between these standards and those that may be set forth 2195 other centers or elsewhere, and the incidence of illness. in local, county, or municipal ordinances shall be resolved in 2196 (7) (g) Components of a comprehensive emergency management favor of those having statewide effect. Such standards must 2197 plan, developed in consultation with the Department of Health 2198 and the Division of Emergency Management. (1) (a) The maintenance of adult day care centers with 2199 (2) Pursuant to this part, s. 408.811, and applicable 2200 rules, the agency may conduct an abbreviated biennial inspection respect to plumbing, heating, lighting, ventilation, and other building conditions, including adequate meeting space, to ensure 2201 of key quality-of-care standards, in lieu of a full inspection, the health, safety, and comfort of participants and protection 2202 of a center that has a record of good performance. However, the from fire hazard. Such standards may not conflict with chapter 2203 agency must conduct a full inspection of a center that has had 553 and must be based upon the size of the structure and the 2204 one or more confirmed complaints within the licensure period Page 76 of 81 CODING: Words stricken are deletions; words underlined are additions.

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the agency.

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established:

chapter 460.

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20201726c1 588-02756-20 20201726c1 2234 immediately preceding the inspection or which has a serious 464. problem identified during the abbreviated inspection. The agency 2235 9. Nursing assistants, as provided under part II of chapter shall develop the key quality-of-care standards, taking into 2236 464. consideration the comments and recommendations of provider 2237 10. The Board of Pharmacy, created under chapter 465. groups. These standards shall be included in rules adopted by 2238 11. The Board of Dentistry, created under chapter 466. 2239 12. Midwifery, as provided under chapter 467. Section 44. Part I of chapter 483, Florida Statutes, is 2240 13. The Board of Speech-Language Pathology and Audiology, repealed, and part II and part III of that chapter are 2241 created under part I of chapter 468. redesignated as part I and part II, respectively. 2242 14. The Board of Nursing Home Administrators, created under Section 45. Paragraph (g) of subsection (3) of section 2243 part II of chapter 468. 20.43, Florida Statutes, is amended to read: 2244 15. The Board of Occupational Therapy, created under part 20.43 Department of Health.-There is created a Department 2245 III of chapter 468. 16. Respiratory therapy, as provided under part V of 2246 (3) The following divisions of the Department of Health are 2247 chapter 468. 2248 17. Dietetics and nutrition practice, as provided under (g) Division of Medical Quality Assurance, which is 2249 part X of chapter 468. responsible for the following boards and professions established 2250 18. The Board of Athletic Training, created under part XIII within the division: 2251 of chapter 468. 1. The Board of Acupuncture, created under chapter 457. 2252 19. The Board of Orthotists and Prosthetists, created under 2. The Board of Medicine, created under chapter 458. 2253 part XIV of chapter 468. 3. The Board of Osteopathic Medicine, created under chapter 20. Electrolysis, as provided under chapter 478. 2254 2255 21. The Board of Massage Therapy, created under chapter 4. The Board of Chiropractic Medicine, created under 2256 480. 2257 22. The Board of Clinical Laboratory Personnel, created 5. The Board of Podiatric Medicine, created under chapter 2258 under part I part II of chapter 483. 23. Medical physicists, as provided under part II part III 2259 6. Naturopathy, as provided under chapter 462. 2260 of chapter 483. 7. The Board of Optometry, created under chapter 463. 2261 24. The Board of Opticianry, created under part I of 8. The Board of Nursing, created under part I of chapter 2262 chapter 484. Page 77 of 81 Page 78 of 81 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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2263	25. The Board of Hearing Aid Specialists, created under	2292		
2264	part II of chapter 484.	2293		
2265	26. The Board of Physical Therapy Practice, created under	2294		
2266	chapter 486.	2295		
2267	27. The Board of Psychology, created under chapter 490.	2296		
2268	28. School psychologists, as provided under chapter 490.	2297		
2269	29. The Board of Clinical Social Work, Marriage and Family	2298		
2270	Therapy, and Mental Health Counseling, created under chapter	2299		
2271	491.	2300	(2) As used in this section, the terms "records owner,"	
2272	30. Emergency medical technicians and paramedics, as	2301	"health care practitioner," and "health care practitioner's	
2273	provided under part III of chapter 401.	2302	employer" do not include any of the following persons or	
2274	Section 46. Subsection (3) of section 381.0034, Florida	2303	entities; furthermore, the following persons or entities are not	
2275	Statutes, is amended to read:	2304	authorized to acquire or own medical records, but are authorized	
2276	381.0034 Requirement for instruction on HIV and AIDS	2305	under the confidentiality and disclosure requirements of this	
2277	(3) The department shall require, as a condition of	2306	section to maintain those documents required by the part or	
2278	granting a license under chapter 467 or <u>part I</u> <del>part II</del> of	2307	chapter under which they are licensed or regulated:	
2279	chapter 483, that an applicant making initial application for	2308	(h) Clinical laboratory personnel licensed under part $I$	
2280	licensure complete an educational course acceptable to the	2309	<del>part II</del> of chapter 483.	
2281	department on human immunodeficiency virus and acquired immune	2310	(i) Medical physicists licensed under part II part III of	
2282	deficiency syndrome. Upon submission of an affidavit showing	2311	chapter 483.	
2283	good cause, an applicant who has not taken a course at the time	2312	Section 49. Paragraph (j) of subsection (1) of section	
2284	of licensure shall be allowed 6 months to complete this	2313	456.076, Florida Statutes, is amended to read:	
2285	requirement.	2314	456.076 Impaired practitioner programs	
2286	Section 47. Subsection (4) of section 456.001, Florida	2315	(1) As used in this section, the term:	
2287	Statutes, is amended to read:	2316	(j) "Practitioner" means a person licensed, registered,	
2288	456.001 Definitions.—As used in this chapter, the term:	2317	certified, or regulated by the department under part III of	
2289	(4) "Health care practitioner" means any person licensed	2318	chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;	
2290	under chapter 457; chapter 458; chapter 459; chapter 460;	2319	chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;	
2291	chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;	2320	chapter 466; chapter 467; part I, part II, part III, part V,	
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part X, part XIII, or part XIV of chapter 468; chapter 478;
chapter 480; <u>part I or part II</u> <del>part II or part III</del> 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) DEFINITIONSAs 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; <u>part I or part II</u>
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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House

Florida Senate - 2020 Bill No. CS for SB 1726

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LEGISLATIVE ACTION

Senate Comm: RCS 02/25/2020

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 <u>and the</u> agency.

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11 (4) A report shall be submitted annually to the agency. The 12 contents of the report and the frequency with which it is 13 submitted shall be prescribed by rule of the agency. 14 Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read: 15 16 395.003 Licensure; denial, suspension, and revocation.-17 (4) The agency shall issue a license that which specifies 18 the service categories and the number of hospital beds in each bed category for which a license is received. Such information 19 20 shall be listed on the face of the license. All beds which are 21 not covered by any specialty-bed-need methodology shall be 22 specified as general beds. A licensed facility shall not operate 23 a number of hospital beds greater than the number indicated by 24 the agency on the face of the license without approval from the 25 agency under conditions established by rule. 26 Section 3. Paragraph (g) is added to subsection (18) of 27 section 395.1055, Florida Statutes, to read: 395.1055 Rules and enforcement.-28 (18) In establishing rules for adult cardiovascular 29 30 services, the agency shall include provisions that allow for: 31 (g) The requirement that hospitals licensed for adult diagnostic cardiac catheterization, Level I or Level II adult 32 33 cardiovascular services participate in the American College of 34 Cardiology - National Cardiovascular Data Registry or the 35 American Heart Association's Get with the Guidelines - Coronary 36 Artery Disease program registry and document an ongoing quality 37 improvement plan to ensure these licensed programs meet or 38 exceed national quality and outcome benchmarks reported by the 39 registry in which they participate. Hospitals licensed for Level

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40	II adult cardiovascular services must also participate in the
41	clinical outcome reporting systems operated by the Society for
42	Thoracic Surgeons.
43	Section 4. Paragraph (b) of subsection (2) of section
44	395.602, Florida Statutes, is amended to read:
45	395.602 Rural hospitals
46	(2) DEFINITIONSAs used in this part, the term:
47	(b) "Rural hospital" means an acute care hospital licensed
48	under this chapter, having 100 or fewer licensed beds and an
49	emergency room, which is:
50	1. The sole provider within a county with a population
51	density of up to 100 persons per square mile;
52	2. An acute care hospital, in a county with a population
53	density of up to 100 persons per square mile, which is at least
54	30 minutes of travel time, on normally traveled roads under
55	normal traffic conditions, from any other acute care hospital
56	within the same county;
57	3. A hospital supported by a tax district or subdistrict
58	whose boundaries encompass a population of up to 100 persons per
59	square mile;
60	4. A hospital classified as a sole community hospital under
61	42 C.F.R. s. 412.92, regardless of the number of licensed beds;
62	5. A hospital with a service area that has a population of
63	up to 100 persons per square mile. As used in this subparagraph,
64	the term "service area" means the fewest number of zip codes
65	that account for 75 percent of the hospital's discharges for the
66	most recent 5-year period, based on information available from
67	the hospital inpatient discharge database in the Florida Center
68	for Health Information and Transparency at the agency; or

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69 6. A hospital designated as a critical access hospital, as70 defined in s. 408.07.

72 Population densities used in this paragraph must be based upon 73 the most recently completed United States census. A hospital 74 that received funds under s. 409.9116 for a quarter beginning no 75 later than July 1, 2002, is deemed to have been and shall 76 continue to be a rural hospital from that date through June 30, 77 2021, if the hospital continues to have up to 100 licensed beds 78 and an emergency room. An acute care hospital that has not 79 previously been designated as a rural hospital and that meets 80 the criteria of this paragraph shall be granted such designation 81 upon application, including supporting documentation, to the 82 agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a 83 rural hospital from the date of designation through June 30, 84 85 2025 <del>2021</del>, if the hospital continues to have up to 100 licensed beds and an emergency room. 86

87 Section 5. <u>Section 395.7015</u>, Florida Statutes, is repealed.
88 Section 6. Section 395.7016, Florida Statutes, is amended
89 to read:

90 395.7016 Annual appropriation.-The Legislature shall 91 appropriate each fiscal year from either the General Revenue 92 Fund or the Agency for Health Care Administration Tobacco 93 Settlement Trust Fund an amount sufficient to replace the funds 94 lost due to reduction by chapter 2000-256, Laws of Florida, of 95 the assessment on other health care entities under s. 395.7015, 96 and the reduction by chapter 2000-256, Laws of Florida, in the 97 assessment on hospitals under s.  $395.701_{\tau}$  and to maintain

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98 federal approval of the reduced amount of funds deposited into 99 the Public Medical Assistance Trust Fund under s.  $395.701_{\tau}$  as 100 state match for the state's Medicaid program.

Section 7. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

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400.19 Right of entry and inspection.-

104 (3) The agency shall conduct periodic, every 15 months 105 conduct at least one unannounced licensure inspections inspection to determine compliance by the licensee with 106 107 statutes, and with rules adopted promulgated under the 108 provisions of those statutes, governing minimum standards of 109 construction, quality and adequacy of care, and rights of 110 residents. The survey shall be conducted every 6 months for the 111 next 2-year period If the facility has been cited for a class I 112 deficiency or  $_{\overline{\tau}}$  has been cited for two or more class II 113 deficiencies arising from separate surveys or investigations 114 within a 60-day period, the agency shall conduct licensure 115 surveys every 6 months until the facility has two consecutive 116 licensure surveys without a citation for a class I or a class II 117 deficiency or has had three or more substantiated complaints 118 within a 6-month period, each resulting in at least one class I 119 or class II deficiency. In addition to any other fees or fines 120 in this part, the agency shall assess a fine of for each 121 facility that is subject to the 6-month survey cycle. The fine 122 for the 2-year period shall be \$6,000 for the additional 6-month 123 licensure surveys, one-half to be paid at the completion of each 124 survey. The agency may adjust such this fine by the change in the Consumer Price Index, based on the 12 months immediately 125 126 preceding the increase, to cover the cost of the additional

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127 surveys. The agency shall verify through subsequent inspection 128 that any deficiency identified during inspection is corrected. 129 However, the agency may verify the correction of a class III or 130 class IV deficiency unrelated to resident rights or resident 131 care without reinspecting the facility if adequate written 132 documentation has been received from the facility, which 133 provides assurance that the deficiency has been corrected. The 134 giving or causing to be given of advance notice of such 135 unannounced inspections by an employee of the agency to any 136 unauthorized person shall constitute cause for suspension of not 137 fewer than 5 working days according to the provisions of chapter 138 110.

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 149 following:

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(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

153 (d) Dietetics and nutrition practice and nutrition 154 counseling.

(e) Medical supplies, restricted to drugs and biologicals

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(17) "Home infusion therapy provider" means a person who an 157 organization that employs, contracts with, or refers a licensed 159 professional who has received advanced training and experience 160 in intravenous infusion therapy and who administers infusion 161 therapy to a patient in the patient's home or place of 162 residence.

163 (21) "Nurse registry" means any person who that procures, 164 offers, promises, or attempts to secure health-care-related 165 contracts for registered nurses, licensed practical nurses, 166 certified nursing assistants, home health aides, companions, or 167 homemakers, who are compensated by fees as independent 168 contractors, including, but not limited to, contracts for the 169 provision of services to patients and contracts to provide 170 private duty or staffing services to health care facilities 171 licensed under chapter 395, this chapter, or chapter 429 or 172 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.

183 Section 9. Subsection (1), paragraph (a) of subsection (4), and subsection (5) of section 400.464, Florida Statutes, are 184



185 amended to read:

186 400.464 Home health agencies to be licensed; expiration of 187 license; exemptions; unlawful acts; penalties.-

188 (1) The requirements of part II of chapter 408 apply to the 189 provision of services that require licensure pursuant to this 190 part and part II of chapter 408 and entities licensed or 191 registered by or applying for such licensure or registration 192 from the Agency for Health Care Administration pursuant to this 193 part. A license issued by the agency is required in order to 194 operate a home health agency in this state. A license issued on 195 or after July 1, 2018, must specify the home health services the 196 licensee organization is authorized to perform and indicate 197 whether such specified services are considered skilled care. The 198 provision or advertising of services that require licensure 199 pursuant to this part without such services being specified on 200 the face of the license issued on or after July 1, 2018, 201 constitutes unlicensed activity as prohibited under s. 408.812.

202 (4) (a) A licensee An organization that offers or advertises 203 to the public any service for which licensure or registration is 204 required under this part must include in the advertisement the 205 license number or registration number issued to the licensee 206 organization by the agency. The agency shall assess a fine of 207 not less than \$100 to any licensee or registrant who fails to 2.08 include the license or registration number when submitting the 209 advertisement for publication, broadcast, or printing. The fine 210 for a second or subsequent offense is \$500. The holder of a 211 license issued under this part may not advertise or indicate to 212 the public that it holds a home health agency or nurse registry 213 license other than the one it has been issued.

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214 (5) The following are exempt from the licensure as a home 215 health agency under requirements of this part: (a) A home health agency operated by the Federal 216 217 Government. 218 (b) Home health services provided by a state agency, either 219 directly or through a contractor with: 220 1. The Department of Elderly Affairs. 221 2. The Department of Health, a community health center, or 2.2.2 a rural health network that furnishes home visits for the 223 purpose of providing environmental assessments, case management, 224 health education, personal care services, family planning, or 225 followup treatment, or for the purpose of monitoring and 226 tracking disease. 3. Services provided to persons with developmental 227 228 disabilities, as defined in s. 393.063. 229 4. Companion and sitter organizations that were registered 230 under s. 400.509(1) on January 1, 1999, and were authorized to 231 provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide 232 233 such services to past, present, and future clients of the 234 organization who need such services, notwithstanding the 235 provisions of this act. 236 5. The Department of Children and Families. 237 (c) A health care professional, whether or not 238 incorporated, who is licensed under chapter 457; chapter 458; 239 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

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(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.

248 (e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a 249 250 licensed home health agency or registered with a licensed nurse 251 registry. This exemption does not entitle an individual to 252 perform home health services without the required professional 253 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 269 419, to serve the residents in its facility.

270 (1) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers. 271

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272	(m) Certified rehabilitation agencies and comprehensive
273	outpatient rehabilitation facilities that are certified under
274	Title 18 of the Social Security Act.
275	(n) The delivery of adult family-care home services for
276	which the adult family-care home is licensed under part II of
277	chapter 429, to serve the residents in its facility.
278	(o) A person who provides skilled care by health care
279	professionals licensed solely under part I of chapter 464; part
280	I, part III, or part V of chapter 468; or chapter 486. This
281	exemption does not authorize an individual to perform home
282	health services without the required professional license.
283	(p) A person or entity that provides services using only
284	volunteers or only individuals related by blood or marriage to
285	the patient or client.
286	Section 10. Paragraph (g) of subsection (2) of section
287	400.471, Florida Statutes, is amended to read:
288	400.471 Application for license; fee
289	(2) In addition to the requirements of part II of chapter
290	408, the initial applicant, the applicant for a change of
291	ownership, and the applicant for the addition of skilled care
292	services must file with the application satisfactory proof that
293	the home health agency is in compliance with this part and
294	applicable rules, including:
295	(g) In the case of an application for initial licensure, an
296	application for a change of ownership, or an application for the
297	addition of skilled care services, documentation of
298	accreditation, or an application for accreditation, from an
299	accrediting organization that is recognized by the agency as
300	having standards comparable to those required by this part and

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301 part II of chapter 408. A home health agency that does not 302 provide skilled care is exempt from this paragraph. 303 Notwithstanding s. 408.806, the an initial applicant must 304 provide proof of accreditation that is not conditional or 305 provisional and a survey demonstrating compliance with the 306 requirements of this part, part II of chapter 408, and 307 applicable rules from an accrediting organization that is 308 recognized by the agency as having standards comparable to those 309 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 310 311 licensure. Such accreditation must be continuously maintained by 312 the home health agency to maintain licensure. The agency shall 313 accept, in lieu of its own periodic licensure survey, the 314 submission of the survey of an accrediting organization that is 315 recognized by the agency if the accreditation of the licensed 316 home health agency is not provisional and if the licensed home 317 health agency authorizes release of, and the agency receives the 318 report of, the accrediting organization.

319 Section 11. Section 400.492, Florida Statutes, is amended 320 to read:

321 400.492 Provision of services during an emergency.-Each 322 home health agency shall prepare and maintain a comprehensive 323 emergency management plan that is consistent with the standards 324 adopted by national or state accreditation organizations and 325 consistent with the local special needs plan. The plan shall be 326 updated annually and shall provide for continuing home health 327 services during an emergency that interrupts patient care or 328 services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff 329

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330 to perform the same type and quantity of services to their 331 patients who evacuate to special needs shelters that were being 332 provided to those patients prior to evacuation. The plan shall 333 describe how the home health agency establishes and maintains an 334 effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; 335 336 providing for communication between staff members, county health 337 departments, and local emergency management agencies, including 338 a backup system; identifying resources necessary to continue 339 essential care or services or referrals to other health care 340 providers organizations subject to written agreement; and 341 prioritizing and contacting patients who need continued care or 342 services.

343 (1) Each patient record for patients who are listed in the 344 registry established pursuant to s. 252.355 shall include a 345 description of how care or services will be continued in the 346 event of an emergency or disaster. The home health agency shall 347 discuss the emergency provisions with the patient and the 348 patient's caregivers, including where and how the patient is to 349 evacuate, procedures for notifying the home health agency in the 350 event that the patient evacuates to a location other than the 351 shelter identified in the patient record, and a list of 352 medications and equipment which must either accompany the 353 patient or will be needed by the patient in the event of an 354 evacuation.

355 (2) Each home health agency shall maintain a current 356 prioritized list of patients who need continued services during 357 an emergency. The list shall indicate how services shall be 358 continued in the event of an emergency or disaster for each

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359 patient and if the patient is to be transported to a special 360 needs shelter, and shall indicate if the patient is receiving 361 skilled nursing services and the patient's medication and 362 equipment needs. The list shall be furnished to county health 363 departments and to local emergency management agencies, upon 364 request.

365 (3) Home health agencies shall not be required to continue 366 to provide care to patients in emergency situations that are 367 beyond their control and that make it impossible to provide 368 services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home 369 370 health agencies may establish links to local emergency 371 operations centers to determine a mechanism by which to approach 372 specific areas within a disaster area in order for the agency to 373 reach its clients. Home health agencies shall demonstrate a good 374 faith effort to comply with the requirements of this subsection 375 by documenting attempts of staff to follow procedures outlined 376 in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that 377 378 the provision of continuing care has been attempted for those 379 patients who have been identified as needing care by the home 380 health agency and registered under s. 252.355, in the event of 381 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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388 400.506 Licensure of nurse registries; requirements; 389 penalties.-390 (4) A licensee who person that provides, offers, or 391 advertises to the public any service for which licensure is 392 required under this section must include in such advertisement 393 the license number issued to the licensee it by the Agency for Health Care Administration. The agency shall assess a fine of 394 395 not less than \$100 against any licensee who fails to include the license number when submitting the advertisement for 396 397 publication, broadcast, or printing. The fine for a second or 398 subsequent offense is \$500.

(5) (a) In addition to the requirements of s. 408.812, any person <u>or entity that</u> 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:

408 400.509 Registration of particular service providers exempt 409 from licensure; certificate of registration; regulation of 410 registrants.-

(1) Any <u>person who</u> 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 <u>person who</u> organization that provides companion services or homemaker services must register with the agency. <u>A person An organization</u> under contract with the Agency

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417 for Persons with Disabilities <u>who</u> which provides companion 418 services only for persons with a developmental disability, as 419 defined in s. 393.063, is exempt from registration.

420 (2) The requirements of part II of chapter 408 apply to the 421 provision of services that require registration or licensure 422 pursuant to this section and part II of chapter 408 and entities 423 registered by or applying for such registration from the Agency 424 for Health Care Administration pursuant to this section. Each 425 applicant for registration and each registrant must comply with 426 all provisions of part II of chapter 408. Registration or a 427 license issued by the agency is required for a person to provide 428 the operation of an organization that provides companion 429 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 <u>person</u> <del>organization</del> 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.

441 There is no monetary liability on the part of, and no cause of 442 action for damages arises against, a former employer of a 443 prospective employee of or prospective independent contractor 444 with a registrant who reasonably and in good faith communicates 445 his or her honest opinions about the former employee's or

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446 contractor's job performance. This subsection does not affect 447 the official immunity of an officer or employee of a public 448 corporation.

449 (5) A person who that offers or advertises to the public a
450 service for which registration is required must include in its
451 advertisement the registration number issued by the Agency for
452 Health Care Administration.

453 Section 14. Subsection (3) of section 400.605, Florida 454 Statutes, is amended to read:

455 400.605 Administration; forms; fees; rules; inspections; 456 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 3year 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:

466 400.60501 Outcome measures; adoption of federal quality 467 measures; public reporting; annual report.-

468 (1) No later than December 31, 2019, The agency shall adopt
469 the national hospice outcome measures and survey data in 42
470 C.F.R. part 418 to determine the quality and effectiveness of
471 hospice care for hospices licensed in the state.

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(2) The agency shall +

473 (a) make available to the public the national hospice
474 outcome measures and survey data in a format that is

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475 comprehensible by a layperson and that allows a consumer to 476 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 479 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 483 484 provided to individuals and which tenders charges for 485 reimbursement for such services, including a mobile clinic and a 486 portable equipment provider. As used in this part, the term does 487 not include and the licensure requirements of this part do not 488 apply to:

489 (a) Entities licensed or registered by the state under 490 chapter 395; entities licensed or registered by the state and 491 providing only health care services within the scope of services 492 authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter 493 494 except part X, chapter 429, chapter 463, chapter 465, chapter 495 466, chapter 478, chapter 484, or chapter 651; end-stage renal 496 disease providers authorized under 42 C.F.R. part 405, subpart 497 U; providers certified and providing only health care services 498 within the scope of services authorized under their respective 499 certifications under 42 C.F.R. part 485, subpart B, or subpart 500 H, or subpart J; providers certified and providing only health 501 care services within the scope of services authorized under 502 their respective certifications under 42 C.F.R. part 486, 503 subpart C; providers certified and providing only health care

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504 services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; 505 506 providers certified by the Centers for Medicare and Medicaid 507 services under the federal Clinical Laboratory Improvement 508 Amendments and the federal rules adopted thereunder; or any 509 entity that provides neonatal or pediatric hospital-based health 510 care services or other health care services by licensed 511 practitioners solely within a hospital licensed under chapter 512 395.

513 (b) Entities that own, directly or indirectly, entities 514 licensed or registered by the state pursuant to chapter 395; 515 entities that own, directly or indirectly, entities licensed or 516 registered by the state and providing only health care services 517 within the scope of services authorized pursuant to their 518 respective licenses under ss. 383.30-383.332, chapter 390, 519 chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 520 521 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers 522 523 certified and providing only health care services within the 524 scope of services authorized under their respective 525 certifications under 42 C.F.R. part 485, subpart B, or subpart 526 H, or subpart J; providers certified and providing only health 527 care services within the scope of services authorized under 528 their respective certifications under 42 C.F.R. part 486, 529 subpart C; providers certified and providing only health care 530 services within the scope of services authorized under their 531 respective certifications under 42 C.F.R. part 491, subpart A; 532 providers certified by the Centers for Medicare and Medicaid

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533 services under the federal Clinical Laboratory Improvement 534 Amendments and the federal rules adopted thereunder; or any 535 entity that provides neonatal or pediatric hospital-based health 536 care services by licensed practitioners solely within a hospital 537 licensed under chapter 395.

538 (c) Entities that are owned, directly or indirectly, by an 539 entity licensed or registered by the state pursuant to chapter 540 395; entities that are owned, directly or indirectly, by an 541 entity licensed or registered by the state and providing only 542 health care services within the scope of services authorized 543 pursuant to their respective licenses under ss. 383.30-383.332, 544 chapter 390, chapter 394, chapter 397, this chapter except part 545 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 546 478, chapter 484, or chapter 651; end-stage renal disease 547 providers authorized under 42 C.F.R. part 405, subpart U; providers certified and providing only health care services 548 549 within the scope of services authorized under their respective 550 certifications under 42 C.F.R. part 485, subpart B, or subpart 551 H, or subpart J; providers certified and providing only health 552 care services within the scope of services authorized under 553 their respective certifications under 42 C.F.R. part 486, 554 subpart C; providers certified and providing only health care 555 services within the scope of services authorized under their 556 respective certifications under 42 C.F.R. part 491, subpart A; 557 providers certified by the Centers for Medicare and Medicaid 558 services under the federal Clinical Laboratory Improvement 559 Amendments and the federal rules adopted thereunder; or any 560 entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital 561

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562 under chapter 395.

(d) Entities that are under common ownership, directly or 563 564 indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common 565 566 ownership, directly or indirectly, with an entity licensed or 567 registered by the state and providing only health care services 568 within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, 569 570 chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 571 572 484, or chapter 651; end-stage renal disease providers 573 authorized under 42 C.F.R. part 405, subpart U; providers 574 certified and providing only health care services within the 575 scope of services authorized under their respective 576 certifications under 42 C.F.R. part 485, subpart B, or subpart 577 H, or subpart J; providers certified and providing only health 578 care services within the scope of services authorized under 579 their respective certifications under 42 C.F.R. part 486, 580 subpart C; providers certified and providing only health care 581 services within the scope of services authorized under their 582 respective certifications under 42 C.F.R. part 491, subpart A; 583 providers certified by the Centers for Medicare and Medicaid 584 services under the federal Clinical Laboratory Improvement 585 Amendments and the federal rules adopted thereunder; or any 586 entity that provides neonatal or pediatric hospital-based health 587 care services by licensed practitioners solely within a hospital 588 licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan



591 under 26 U.S.C. s. 409 that has a board of trustees at least 592 two-thirds of which are Florida-licensed health care 593 practitioners and provides only physical therapy services under 594 physician orders, any community college or university clinic, 595 and any entity owned or operated by the federal or state 596 government, including agencies, subdivisions, or municipalities 597 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.

604 (g) A sole proprietorship, group practice, partnership, or 605 corporation that provides health care services by licensed 606 health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, 607 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, 608 609 chapter 490, chapter 491, or part I, part III, part X, part 610 XIII, or part XIV of chapter 468, or s. 464.012, and that is 611 wholly owned by one or more licensed health care practitioners, 612 or the licensed health care practitioners set forth in this 613 paragraph and the spouse, parent, child, or sibling of a 614 licensed health care practitioner if one of the owners who is a 615 licensed health care practitioner is supervising the business 616 activities and is legally responsible for the entity's 617 compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of 618 the practitioner's license, except that, for the purposes of 619

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620 this part, a clinic owned by a licensee in s. 456.053(3)(b) 621 which provides only services authorized pursuant to s. 622 456.053(3)(b) may be supervised by a licensee specified in s. 623 456.053(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.

(1) 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



649 corporation is a corporation that issues securities traded on an
650 exchange registered with the United States Securities and
651 Exchange Commission as a national securities exchange.
652 (m) Entities that are owned by a corporation that has \$250

(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.

660 (n) Entities that employ 50 or more licensed health care 661 practitioners licensed under chapter 458 or chapter 459 where 662 the billing for medical services is under a single tax 663 identification number. The application for exemption under this 664 subsection shall contain information that includes: the name, 665 residence, and business address and phone number of the entity 666 that owns the practice; a complete list of the names and contact information of all the officers and directors of the 667 668 corporation; the name, residence address, business address, and 669 medical license number of each licensed Florida health care 670 practitioner employed by the entity; the corporate tax 671 identification number of the entity seeking an exemption; a 672 listing of health care services to be provided by the entity at 673 the health care clinics owned or operated by the entity and a 674 certified statement prepared by an independent certified public 675 accountant which states that the entity and the health care 676 clinics owned or operated by the entity have not received payment for health care services under personal injury 677

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678 protection insurance coverage for the preceding year. If the 679 agency determines that an entity which is exempt under this subsection has received payments for medical services under 680 681 personal injury protection insurance coverage, the agency may 682 deny or revoke the exemption from licensure under this 683 subsection. 684 (o) Entities that are, directly or indirectly, under the 685 common ownership of or that are subject to common control by a mutual insurance holding company, as defined in s. 628.703, with 686 687 an entity licensed or certified under chapter 627 or chapter 641 688 which has \$1 billion or more in total annual sales in this 689 state. 690 (p) Entities that are owned by an entity that is a 691 behavioral health service provider in at least 5 states other 692 than Florida and that, together with its affiliates, has \$90 693 million or more in total annual revenues associated with the 694 provision of behavioral health services and where one or more of 695 the persons responsible for the operations of the entity is a 696 health care practitioner who is licensed in this state and who 697 is responsible for supervising the business activities of the 698 entity and for the entity's compliance with state law for 699 purposes of this part. 700 (q) Medicaid providers. 701

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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707 400.991, Florida Statutes, is amended to read: 708 400.991 License requirements; background screenings; prohibitions.-709 710 (3) In addition to the requirements of part II of chapter 711 408, the applicant must file with the application satisfactory 712 proof that the clinic is in compliance with this part and 713 applicable rules, including: 714 (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 715 716 to submitting proof of financial ability to operate as required 717 under s. 408.810(8), the applicant may file a surety bond of at 718 least \$500,000 which guarantees that the clinic will act in full 719 conformity with all legal requirements for operating a clinic, 720 payable to the agency. The agency may adopt rules to specify 721 related requirements for such surety bond. 722 Section 18. Paragraph (i) of subsection (1) of section 723 400.9935, Florida Statutes, is amended to read: 724 400.9935 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. <u>The</u>
<u>schedule may group services by price levels</u>, <u>listing services in</u>
<u>each price level</u>. The schedule must be posted in a conspicuous
place in the reception area of <u>any clinic that is an the</u> urgent

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736 care center as defined in s. 395.002(29)(b) and must include, 737 but is not limited to, the 50 services most frequently provided 738 by the clinic. The schedule may group services by three price 739 levels, listing services in each price level. The posting may be 740 a sign that must be at least 15 square feet in size or through 741 an electronic messaging board that is at least 3 square feet in 742 size. The failure of a clinic, including a clinic that is an 743 urgent care center, to publish and post a schedule of charges as 744 required by this section shall result in a fine of not more than 745 \$1,000, per day, until the schedule is published and posted. 746 Section 19. Paragraph (a) of subsection (2) of section 747 408.033, Florida Statutes, is amended to read: 748 408.033 Local and state health planning.-749 (2) FUNDING.-750 (a) The Legislature intends that the cost of local health 751 councils be borne by assessments on selected health care 752 facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted 753 754 living facilities, ambulatory surgical centers, birth centers, 755 home health agencies, hospices, hospitals, intermediate care 756 facilities for the developmentally disabled, nursing homes, and 757 health care clinics, and multiphasic testing centers and by 758 assessments on organizations subject to certification by the 759 agency pursuant to chapter 641, part III, including health 760 maintenance organizations and prepaid health clinics. Fees 761 assessed may be collected prospectively at the time of licensure 762 renewal and prorated for the licensure period.

763 Section 20. Effective January 1, 2021, paragraph (1) is 764 added to subsection (3) of section 408.05, Florida Statutes, to

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765 read: 766 408.05 Florida Center for Health Information and 767 Transparency.-768 (3) HEALTH INFORMATION TRANSPARENCY.-In order to 769 disseminate and facilitate the availability of comparable and 770 uniform health information, the agency shall perform the 771 following functions: 772 (1) By July 1 of each year, publish a report identifying 773 the health care services with the most significant price 774 variation both statewide and regionally. 775 Section 21. Paragraph (a) of subsection (1) of section 776 408.061, Florida Statutes, is amended to read: 777 408.061 Data collection; uniform systems of financial 778 reporting; information relating to physician charges; 779 confidential information; immunity.-780 (1) The agency shall require the submission by health care 781 facilities, health care providers, and health insurers of data 782 necessary to carry out the agency's duties and to facilitate 783 transparency in health care pricing data and quality measures. 784 Specifications for data to be collected under this section shall 785 be developed by the agency and applicable contract vendors, with 786 the assistance of technical advisory panels including 787 representatives of affected entities, consumers, purchasers, and 788 such other interested parties as may be determined by the 789 agency. 790 (a) Data submitted by health care facilities, including the 791 facilities as defined in chapter 395, shall include, but are not 792 limited to, + case-mix data, patient admission and discharge 793 data, hospital emergency department data which shall include the

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794 number of patients treated in the emergency department of a 795 licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on 796 797 complications as specified by rule, data on readmissions as 798 specified by rule, including patient- with patient and provider-799 specific identifiers included, actual charge data by diagnostic 800 groups or other bundled groupings as specified by rule, 801 financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not 802 803 pay, interest charges, depreciation expenses based on the 804 expected useful life of the property and equipment involved, and 805 demographic data. The agency shall adopt nationally recognized 806 risk adjustment methodologies or software consistent with the 807 standards of the Agency for Healthcare Research and Quality and 808 as selected by the agency for all data submitted as required by 809 this section. Data may be obtained from documents including such 810 as, but not limited to, + leases, contracts, debt instruments, 811 itemized patient statements or bills, medical record abstracts, 812 and related diagnostic information. Reported Data elements shall 813 be reported electronically in accordance with the inpatient data 814 reporting instructions as prescribed by agency rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified 815 816 by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility 817 818 that the information submitted is true and accurate. 819 Section 22. Subsection (4) of section 408.0611, Florida

820 Statutes, is amended to read:

821 822 408.0611 Electronic prescribing clearinghouse.-(4) Pursuant to s. 408.061, the agency shall monitor the



823 implementation of electronic prescribing by health care 824 practitioners, health care facilities, and pharmacies. By 825 January 31 of each year, The agency shall report annually on its 826 website on the progress of implementation of electronic 827 prescribing to the Governor and the Legislature. Information 828 reported pursuant to this subsection must shall include federal 829 and private sector electronic prescribing initiatives and, to 830 the extent that data is readily available from organizations that operate electronic prescribing networks, the number of 8.31 832 health care practitioners using electronic prescribing and the 833 number of prescriptions electronically transmitted.

Section 23. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:

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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:

842 (i) The use of emergency department services by patient acuity level and the implication of increasing hospital cost by 843 844 providing nonurgent care in emergency departments. The agency 845 shall annually publish on its website information submit an 846 annual report based on this monitoring and assessment to the 847 Governor, the Speaker of the House of Representatives, the 848 President of the Senate, and the substantive legislative committees, due January 1. 849

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes,

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852 length of stay, and performance indicators collected from health 853 care facilities pursuant to s. 408.061(1)(a) for specific 854 medical conditions, surgeries, and procedures provided in 855 inpatient and outpatient facilities as determined by the agency. 856 In making the determination of specific medical conditions, 857 surgeries, and procedures to include, the agency shall consider 858 such factors as volume, severity of the illness, urgency of 859 admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators 860 861 shall be risk adjusted or severity adjusted, as applicable, 862 using nationally recognized risk adjustment methodologies or 863 software consistent with the standards of the Agency for 864 Healthcare Research and Quality and as selected by the agency. 865 The website shall also provide an interactive search that allows 866 consumers to view and compare the information for specific 867 facilities, a map that allows consumers to select a county or 868 region, definitions of all of the data, descriptions of each 869 procedure, and an explanation about why the data may differ from 870 facility to facility. Such public data shall be updated 871 quarterly. The agency shall annually publish on its website 872 information submit an annual status report on the collection of 873 data and publication of health care quality measures to the 874 Governor, the Speaker of the House of Representatives, the 875 President of the Senate, and the substantive legislative 876 committees, due January 1. 877 Section 24. Subsection (5) of section 408.063, Florida

878 Statutes, is amended to read:

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408.063 Dissemination of health care information.-(5) The agency shall publish annually a comprehensive

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881	report of state health expenditures. The report shall identify:
882	(a) The contribution of health care dollars made by all
883	<del>payors.</del>
884	(b) The dollars expended by type of health care service in
885	Florida.
886	Section 25. Section 408.802, Florida Statutes, is amended
887	to read:
888	408.802 Applicability.— <del>The provisions of</del> This part <u>applies</u>
889	apply to the provision of services that require licensure as
890	defined in this part and to the following entities licensed,
891	registered, or certified by the agency, as described in chapters
892	112, 383, 390, 394, 395, 400, 429, 440, <del>483,</del> and 765:
893	(1) Laboratories authorized to perform testing under the
894	Drug-Free Workplace Act, as provided under ss. 112.0455 and
895	440.102.
896	(2) Birth centers, as provided under chapter 383.
897	(3) Abortion clinics, as provided under chapter 390.
898	(4) Crisis stabilization units, as provided under parts I
899	and IV of chapter 394.
900	(5) Short-term residential treatment facilities, as
901	provided under parts I and IV of chapter 394.
902	(6) Residential treatment facilities, as provided under
903	part IV of chapter 394.
904	(7) Residential treatment centers for children and
905	adolescents, as provided under part IV of chapter 394.
906	(8) Hospitals, as provided under part I of chapter 395.
907	(9) Ambulatory surgical centers, as provided under part I
908	of chapter 395.
909	(10) Nursing homes, as provided under part II of chapter

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910	400.
911	(11) Assisted living facilities, as provided under part I
912	of chapter 429.
913	(12) Home health agencies, as provided under part III of
914	chapter 400.
915	(13) Nurse registries, as provided under part III of
916	chapter 400.
917	(14) Companion services or homemaker services providers, as
918	provided under part III of chapter 400.
919	(15) Adult day care centers, as provided under part III of
920	chapter 429.
921	(16) Hospices, as provided under part IV of chapter 400.
922	(17) Adult family-care homes, as provided under part II of
923	chapter 429.
924	(18) Homes for special services, as provided under part V
925	of chapter 400.
926	(19) Transitional living facilities, as provided under part
927	XI of chapter 400.
928	(20) Prescribed pediatric extended care centers, as
929	provided under part VI of chapter 400.
930	(21) Home medical equipment providers, as provided under
931	part VII of chapter 400.
932	(22) Intermediate care facilities for persons with
933	developmental disabilities, as provided under part VIII of
934	chapter 400.
935	(23) Health care services pools, as provided under part IX
936	of chapter 400.
937	(24) Health care clinics, as provided under part X of
938	chapter 400.

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939	(25) Multiphasic health testing centers, as provided under
940	part I of chapter 483.
941	(25) <del>(26)</del> Organ, tissue, and eye procurement organizations,
942	as provided under part V of chapter 765.
943	Section 26. Present subsections (10) through (14) of
944	section 408.803, Florida Statutes, are redesignated as
945	subsections (11) through (15), respectively, a new subsection
946	(10) is added to that section, and subsection (3) of that
947	section is amended, to read:
948	408.803 DefinitionsAs used in this part, the term:
949	(3) "Authorizing statute" means the statute authorizing the
950	licensed operation of a provider listed in s. 408.802 and
951	includes chapters 112, 383, 390, 394, 395, 400, 429, 440, <del>483,</del>
952	and 765.
953	(10) "Low-risk provider" means nurse registries, home
954	medical equipment providers, and health care clinics.
955	Section 27. Paragraph (b) of subsection (7) of section
956	408.806, Florida Statutes, is amended to read:
957	408.806 License application process
958	(7)
959	(b) An initial inspection is not required for companion
960	services or homemaker services providers $_{m{ au}}$ as provided under part
961	III of chapter 400, <del>or</del> for health care services pools $_{m{ au}}$ as
962	provided under part IX of chapter 400, or for low-risk providers
963	as provided under s. 408.811.
964	Section 28. Subsection (2) of section 408.808, Florida
965	Statutes, is amended to read:
966	408.808 License categories
967	(2) PROVISIONAL LICENSE.—An applicant against whom a

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968 proceeding denying or revoking a license is pending at the time 969 of license renewal may be issued a provisional license effective 970 until final action not subject to further appeal. A provisional 971 license may also be issued to an applicant <u>for initial licensure</u> 972 <u>or an applicant</u> applying for a change of ownership. A 973 provisional license must be limited in duration to a specific 974 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.-

978 (2) Every 5 years following his or her licensure, 979 employment, or entry into a contract in a capacity that under 980 subsection (1) would require level 2 background screening under 981 chapter 435, each such person must submit to level 2 background 982 rescreening as a condition of retaining such license or 983 continuing in such employment or contractual status. For any 984 such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal 985 986 Bureau of Investigation for a national criminal history record 987 check unless the person's fingerprints are enrolled in the 988 Federal Bureau of Investigation's national retained print arrest 989 notification program. If the fingerprints of such a person are 990 not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints 991 992 electronically to the Department of Law Enforcement for state 993 processing, and the Department of Law Enforcement shall forward 994 the fingerprints to the Federal Bureau of Investigation for a 995 national criminal history record check. The fingerprints shall 996 be retained by the Department of Law Enforcement under s.

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997 943.05(2)(q) and (h) and enrolled in the national retained print 998 arrest notification program when the Department of Law 999 Enforcement begins participation in the program. The cost of the 1000 state and national criminal history records checks required by 1001 level 2 screening may be borne by the licensee or the person 1002 fingerprinted. Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, The agency may accept 1003 1004 as satisfying the requirements of this section proof of 1005 compliance with level 2 screening standards submitted within the 1006 previous 5 years to meet any provider or professional licensure 1007 requirements of the agency, the Department of Health, the 1008 Department of Elderly Affairs, the Agency for Persons with 1009 Disabilities, the Department of Children and Families, or the 1010 Department of Financial Services for an applicant for a 1011 certificate of authority or provisional certificate of authority 1012 to operate a continuing care retirement community under chapter 1013 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 1021 an attestation of compliance with chapter 435 and this section using forms provided by the agency. 1022

(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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1026	in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,
1027	in compliance with the following schedule. If, upon rescreening,
1028	such person has a disqualifying offense that was not a
1029	disqualifying offense at the time of the last screening, but is
1030	a current disqualifying offense and was committed before the
1031	last screening, he or she may apply for an exemption from the
1032	appropriate licensing agency and, if agreed to by the employer,
1033	may continue to perform his or her duties until the licensing
1034	agency renders a decision on the application for exemption if
1035	the person is eligible to apply for an exemption and the
1036	exemption request is received by the agency within 30 days after
1037	receipt of the rescreening results by the person. The
1038	rescreening schedule shall be:
1039	(a) Individuals for whom the last screening was conducted
1040	on or before December 31, 2004, must be rescreened by July 31,
1041	<del>2013.</del>
1042	(b) Individuals for whom the last screening conducted was
1043	between January 1, 2005, and December 31, 2008, must be
1044	rescreened by July 31, 2014.
1045	(c) Individuals for whom the last screening conducted was
1046	between January 1, 2009, through July 31, 2011, must be
1047	rescreened by July 31, 2015.
1048	Section 30. Subsection (1) of section 408.811, Florida
1049	Statutes, is amended to read:
1050	408.811 Right of inspection; copies; inspection reports;
1051	plan for correction of deficiencies
1052	(1) An authorized officer or employee of the agency may
1053	make or cause to be made any inspection or investigation deemed
1054	necessary by the agency to determine the state of compliance

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1055 with this part, authorizing statutes, and applicable rules. The 1056 right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a 1057 1058 license, but inspection of any business suspected of being 1059 operated without the appropriate license may not be made without 1060 the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a 1061 1062 license issued under this part, authorizing statutes, or 1063 applicable rules constitutes permission for an appropriate 1064 inspection to verify the information submitted on or in 1065 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 <u>this section</u>, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from <u>licensure inspection if the provider or controlling interest has</u> <u>an excellent regulatory history with regard to deficiencies,</u> <u>sanctions, complaints, and other regulatory actions, as defined</u> <u>by rule. The agency shall continue to conduct unannounced</u> <u>licensure inspections for at least 10 percent of exempt low-risk</u> <u>providers to verify compliance.</u>

(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:

<u>1. A favorable regulatory history with regard to</u> <u>deficiencies, sanctions, complaints, and other regulatory</u>

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1084	measures.
1085	2. Outcome measures that demonstrate quality performance.
1086	3. Successful participation in a recognized quality
1087	assurance program.
1088	4. Accreditation status.
1089	5. Other measures reflective of quality and safety.
1090	6. The length of time between inspections.
1091	
1092	The agency shall continue to conduct unannounced licensure
1093	inspections for at least 10 percent of providers that qualify
1094	for a waiver or extended period between relicensure inspections.
1095	(e) The agency maintains the authority to conduct an
1096	inspection of any provider at any time to determine regulatory
1097	compliance.
1098	Section 31. Subsection (24) of section 408.820, Florida
1099	Statutes, is amended to read:
1100	408.820 ExemptionsExcept as prescribed in authorizing
1101	statutes, the following exemptions shall apply to specified
1102	requirements of this part:
1103	(24) Multiphasic health testing centers, as provided under
1104	part I of chapter 483, are exempt from s. 408.810(5)-(10).
1105	Section 32. Subsections (1) and (2) of section 408.821,
1106	Florida Statutes, are amended to read:
1107	408.821 Emergency management planning; emergency
1108	operations; inactive license
1109	(1) A licensee required by authorizing statutes and agency
1110	rule to have a comprehensive an emergency management operations
1111	plan must designate a safety liaison to serve as the primary
1112	contact for emergency operations. Such licensee shall submit its

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1113	comprehensive emergency management plan to the local emergency
1114	management agency, county health department, or Department of
1115	Health as follows:
1116	(a) Submit the plan within 30 days after initial licensure
1117	and change of ownership, and notify the agency within 30 days
1118	after submission of the plan.
1119	(b) Submit the plan annually and within 30 days after any
1120	significant modification, as defined by agency rule, to a
1121	previously approved plan.
1122	(c) Respond with necessary plan revisions within 30 days
1123	after notification that plan revisions are required.
1124	(d) Notify the agency within 30 days after approval of its
1125	plan by the local emergency management agency, county health
1126	department, or Department of Health.
1127	(2) An entity subject to this part may temporarily exceed
1128	its licensed capacity to act as a receiving provider in
1129	accordance with an approved <u>comprehensive</u> emergency <u>management</u>
1130	<del>operations</del> plan for up to 15 days. While in an overcapacity
1131	status, each provider must furnish or arrange for appropriate
1132	care and services to all clients. In addition, the agency may
1133	approve requests for overcapacity in excess of 15 days, which
1134	approvals may be based upon satisfactory justification and need
1135	as provided by the receiving and sending providers.
1136	Section 33. Subsection (3) of section 408.831, Florida
1137	Statutes, is amended to read:
1138	408.831 Denial, suspension, or revocation of a license,
1139	registration, certificate, or application
1140	(3) This section provides standards of enforcement
1141	applicable to all entities licensed or regulated by the Agency

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1142 for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 1143 1144 400, 408, 429, 468, <del>483,</del> and 765 or rules adopted pursuant to 1145 those chapters.

1146 Section 34. Section 408.832, Florida Statutes, is amended 1147 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, 1159 and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex 1162 plans and their potential applicability in other settings; shall 1163 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 1167 Speaker of the House of Representatives. Section 36. Paragraph (d) of subsection (10) of section

1168 408.9091, Florida Statutes, is amended to read: 1169 1170 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:

1180 409.905 Mandatory Medicaid services.-The agency may make 1181 payments for the following services, which are required of the 1182 state by Title XIX of the Social Security Act, furnished by 1183 Medicaid providers to recipients who are determined to be 1184 eligible on the dates on which the services were provided. Any 1185 service under this section shall be provided only when medically 1186 necessary and in accordance with state and federal law. 1187 Mandatory services rendered by providers in mobile units to 1188 Medicaid recipients may be restricted by the agency. Nothing in 1189 this section shall be construed to prevent or limit the agency 1190 from adjusting fees, reimbursement rates, lengths of stay, 1191 number of visits, number of services, or any other adjustments 1192 necessary to comply with the availability of moneys and any 1193 limitations or directions provided for in the General Appropriations Act or chapter 216. 1194

(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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1200 inpatient hospital services for a Medicaid recipient 21 years of 1201 age or older to 45 days or the number of days necessary to 1202 comply with the General Appropriations Act.

1203 (a)1. The agency may implement reimbursement and 1204 utilization management reforms in order to comply with any 1205 limitations or directions in the General Appropriations Act, 1206 which may include, but are not limited to: prior authorization 1207 for inpatient psychiatric days; prior authorization for 1208 nonemergency hospital inpatient admissions for individuals 21 1209 years of age and older; authorization of emergency and urgent-1210 care admissions within 24 hours after admission; enhanced 1211 utilization and concurrent review programs for highly utilized 1212 services; reduction or elimination of covered days of service; 1213 adjusting reimbursement ceilings for variable costs; adjusting 1214 reimbursement ceilings for fixed and property costs; and 1215 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.

<u>3.</u> 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.

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4. Upon implementing the prior authorization program for

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1229	hospital inpatient services, the agency shall discontinue its
1230	hospital retrospective review program. However, this
1231	subparagraph may not be construed to prevent the agency from
1232	conducting retrospective reviews under s. 409.913, including,
1233	but not limited to, reviews in which an overpayment is suspected
1234	due to a mistake or submission of an improper claim or for other
1235	reasons that do not rise to the level of fraud or abuse.
1236	Section 38. It is the intent of the Legislature that
1237	section 409.905(5)(a), Florida Statutes, as amended by this act,
1238	confirms and clarifies existing law. This section shall take
1239	effect upon becoming a law.
1240	Section 39. Subsection (8) of section 409.907, Florida
1241	Statutes, is amended to read:
1242	409.907 Medicaid provider agreementsThe agency may make
1243	payments for medical assistance and related services rendered to
1244	Medicaid recipients only to an individual or entity who has a
1245	provider agreement in effect with the agency, who is performing
1246	services or supplying goods in accordance with federal, state,
1247	and local law, and who agrees that no person shall, on the
1248	grounds of handicap, race, color, or national origin, or for any
1249	other reason, be subjected to discrimination under any program
1250	or activity for which the provider receives payment from the
1251	agency.
1252	(8) (a) A level 2 background screening pursuant to chapter
1253	435 must be conducted through the agency on each of the
1254	following:
1255	<u>1. The Each provider</u> , or each principal of the provider if
1256	the provider is a corporation, partnership, association, or
1257	other entity, seeking to participate in the Medicaid program

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1258 must submit a complete set of his or her fingerprints to the 1259 agency for the purpose of conducting a criminal history record 1260 check.

1261 2. Principals of the provider, who include any officer, 1262 director, billing agent, managing employee, or affiliated 1263 person, or any partner or shareholder who has an ownership 1264 interest equal to 5 percent or more in the provider. However, 1265 for a hospital licensed under chapter 395 or a nursing home 1266 licensed under chapter 400, principals of the provider are those 1267 who meet the definition of a controlling interest under s. 1268 408.803. A director of a not-for-profit corporation or 1269 organization is not a principal for purposes of a background 1270 investigation required by this section if the director: serves 1271 solely in a voluntary capacity for the corporation or 1272 organization, does not regularly take part in the day-to-day 1273 operational decisions of the corporation or organization, 1274 receives no remuneration from the not-for-profit corporation or 1275 organization for his or her service on the board of directors, 1276 has no financial interest in the not-for-profit corporation or 1277 organization, and has no family members with a financial 1278 interest in the not-for-profit corporation or organization; and 1279 if the director submits an affidavit, under penalty of perjury, 1280 to this effect to the agency and the not-for-profit corporation 1281 or organization submits an affidavit, under penalty of perjury, 1282 to this effect to the agency as part of the corporation's or 1283 organization's Medicaid provider agreement application.

12843. Any person who participates or seeks to participate in1285the Florida Medicaid program by way of rendering services to1286Medicaid recipients or having direct access to Medicaid

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1287 recipients, recipient living areas, or the financial, medical, 1288 or service records of a Medicaid recipient or who supervises the 1289 delivery of goods or services to a Medicaid recipient. This 1290 subparagraph does not impose additional screening requirements 1291 on any providers licensed under part II of chapter 408 or 1292 transportation service providers contracted with a 1293 transportation broker subject to this paragraph while 1294 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 1306 business or its controlling parent is required to file a form 1308 10-K or other similar statement with the Securities and Exchange 1309 Commission or has a net worth of \$50 million or more.

1310 (d) (b) Background screening shall be conducted in 1311 accordance with chapter 435 and s. 408.809. The cost of the 1312 state and national criminal record check shall be borne by the 1313 provider.

1314 Section 40. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read: 1315

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1316 409.908 Reimbursement of Medicaid providers.-Subject to 1317 specific appropriations, the agency shall reimburse Medicaid 1318 providers, in accordance with state and federal law, according 1319 to methodologies set forth in the rules of the agency and in 1320 policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement 1321 1322 methods based on cost reporting, negotiated fees, competitive 1323 bidding pursuant to s. 287.057, and other mechanisms the agency 1324 considers efficient and effective for purchasing services or 1325 goods on behalf of recipients. If a provider is reimbursed based 1326 on cost reporting and submits a cost report late and that cost 1327 report would have been used to set a lower reimbursement rate 1328 for a rate semester, then the provider's rate for that semester 1329 shall be retroactively calculated using the new cost report, and 1330 full payment at the recalculated rate shall be effected 1331 retroactively. Medicare-granted extensions for filing cost 1332 reports, if applicable, shall also apply to Medicaid cost 1333 reports. Payment for Medicaid compensable services made on 1334 behalf of Medicaid eligible persons is subject to the 1335 availability of moneys and any limitations or directions 1336 provided for in the General Appropriations Act or chapter 216. 1337 Further, nothing in this section shall be construed to prevent 1338 or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or 1339 1340 making any other adjustments necessary to comply with the 1341 availability of moneys and any limitations or directions 1342 provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent. 1343 1344 (1) Reimbursement to hospitals licensed under part I of

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1345 chapter 395 must be made prospectively or on the basis of 1346 negotiation. (a) Reimbursement for inpatient care is limited as provided 1347 1348 in s. 409.905(5), except as otherwise provided in this 1349 subsection. 1350 1. If authorized by the General Appropriations Act, the 1351 agency may modify reimbursement for specific types of services 1352 or diagnoses, recipient ages, and hospital provider types. 1353 2. The agency may establish an alternative methodology to 1354 the DRG-based prospective payment system to set reimbursement 1355 rates for: 1356 a. State-owned psychiatric hospitals. 1357 b. Newborn hearing screening services. 1358 c. Transplant services for which the agency has established 1359 a global fee. 1360 d. Recipients who have tuberculosis that is resistant to 1361 therapy who are in need of long-term, hospital-based treatment 1362 pursuant to s. 392.62. 1363 e. Class III psychiatric hospitals. 1364 3. The agency shall modify reimbursement according to other 1365 methodologies recognized in the General Appropriations Act. 1366 1367 The agency may receive funds from state entities, including, but 1368 not limited to, the Department of Health, local governments, and 1369 other local political subdivisions, for the purpose of making 1370 special exception payments, including federal matching funds, 1371 through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted 1372 1373 for and may not be commingled with other state or local funds in

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1374 any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, 1375 1376 to the extent and in the manner authorized under the General 1377 Appropriations Act and pursuant to an agreement between the 1378 agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local 1379 1380 governmental entity must submit a final, executed letter of 1381 agreement to the agency, which must be received by October 1 of 1382 each fiscal year and provide the total amount of local 1383 governmental funds authorized by the entity for that fiscal year 1384 under this paragraph, paragraph (b), or the General 1385 Appropriations Act. The local governmental entity shall use a 1386 certification form prescribed by the agency. At a minimum, the 1387 certification form must identify the amount being certified and 1388 describe the relationship between the certifying local governmental entity and the local health care provider. The 1389 1390 agency shall prepare an annual statement of impact which 1391 documents the specific activities undertaken during the previous 1392 fiscal year pursuant to this paragraph, to be submitted to the 1393 Legislature annually by January 1. 1394 Section 41. Effective June 30, 2020, section 19 of chapter 1395 2019-116, Laws of Florida, is repealed.

1396 Section 42. Section 409.913, Florida Statutes, is amended 1397 to read:

1398 409.913 Oversight of the integrity of the Medicaid 1399 program.—The agency shall operate a program to oversee the 1400 activities of Florida Medicaid recipients, and providers and 1401 their representatives, to ensure that fraudulent and abusive 1402 behavior and neglect of recipients occur to the minimum extent

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1403 possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 January 1, the agency and the 1404 1405 Medicaid Fraud Control Unit of the Department of Legal Affairs 1406 shall submit reports a joint report to the Legislature 1407 documenting the effectiveness of the state's efforts to control 1408 Medicaid fraud and abuse and to recover Medicaid overpayments 1409 during the previous fiscal year. The report must describe the 1410 number of cases opened and investigated each year; the sources 1411 of the cases opened; the disposition of the cases closed each 1412 year; the amount of overpayments alleged in preliminary and 1413 final audit letters; the number and amount of fines or penalties 1414 imposed; any reductions in overpayment amounts negotiated in 1415 settlement agreements or by other means; the amount of final 1416 agency determinations of overpayments; the amount deducted from 1417 federal claiming as a result of overpayments; the amount of 1418 overpayments recovered each year; the amount of cost of 1419 investigation recovered each year; the average length of time to 1420 collect from the time the case was opened until the overpayment 1421 is paid in full; the amount determined as uncollectible and the 1422 portion of the uncollectible amount subsequently reclaimed from 1423 the Federal Government; the number of providers, by type, that 1424 are terminated from participation in the Medicaid program as a 1425 result of fraud and abuse; and all costs associated with 1426 discovering and prosecuting cases of Medicaid overpayments and 1427 making recoveries in such cases. The report must also document 1428 actions taken to prevent overpayments and the number of 1429 providers prevented from enrolling in or reenrolling in the 1430 Medicaid program as a result of documented Medicaid fraud and 1431 abuse and must include policy recommendations necessary to

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1432 prevent or recover overpayments and changes necessary to prevent 1433 and detect Medicaid fraud. All policy recommendations in the 1434 report must include a detailed fiscal analysis, including, but 1435 not limited to, implementation costs, estimated savings to the 1436 Medicaid program, and the return on investment. The agency must 1437 submit the policy recommendations and fiscal analyses in the 1438 report to the appropriate estimating conference, pursuant to s. 1439 216.137, by February 15 of each year. The agency and the 1440 Medicaid Fraud Control Unit of the Department of Legal Affairs 1441 each must include detailed unit-specific performance standards, 1442 benchmarks, and metrics in the report, including projected cost 1443 savings to the state Medicaid program during the following 1444 fiscal year.

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(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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1461 (d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a 1462 1463 terminal condition, or to prevent, diagnose, correct, cure, 1464 alleviate, or preclude deterioration of a condition that 1465 threatens life, causes pain or suffering, or results in illness 1466 or infirmity, which goods or services are provided in accordance 1467 with generally accepted standards of medical practice. For 1468 purposes of determining Medicaid reimbursement, the agency is 1469 the final arbiter of medical necessity. Determinations of 1470 medical necessity must be made by a licensed physician employed 1471 by or under contract with the agency and must be based upon 1472 information available at the time the goods or services are 1473 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 1482 1483 contract or otherwise, reviews, investigations, analyses, 1484 audits, or any combination thereof, to determine possible fraud, 1485 abuse, overpayment, or recipient neglect in the Medicaid program 1486 and shall report the findings of any overpayments in audit 1487 reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud 1488 detection activities, the agency shall identify and monitor, by 1489

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1490 contract or otherwise, patterns of overutilization of Medicaid 1491 services based on state averages. The agency shall track 1492 Medicaid provider prescription and billing patterns and evaluate 1493 them against Medicaid medical necessity criteria and coverage 1494 and limitation guidelines adopted by rule. Medical necessity 1495 determination requires that service be consistent with symptoms 1496 or confirmed diagnosis of illness or injury under treatment and 1497 not in excess of the patient's needs. The agency shall conduct 1498 reviews of provider exceptions to peer group norms and shall, 1499 using statistical methodologies, provider profiling, and 1500 analysis of billing patterns, detect and investigate abnormal or 1501 unusual increases in billing or payment of claims for Medicaid 1502 services and medically unnecessary provision of services.

1503 (3) The agency may conduct, or may contract for, prepayment 1504 review of provider claims to ensure cost-effective purchasing; 1505 to ensure that billing by a provider to the agency is in 1506 accordance with applicable provisions of all Medicaid rules, 1507 regulations, handbooks, and policies and in accordance with 1508 federal, state, and local law; and to ensure that appropriate 1509 care is rendered to Medicaid recipients. Such prepayment reviews 1510 may be conducted as determined appropriate by the agency, 1511 without any suspicion or allegation of fraud, abuse, or neglect, 1512 and may last for up to 1 year. Unless the agency has reliable 1513 evidence of fraud, misrepresentation, abuse, or neglect, claims 1514 shall be adjudicated for denial or payment within 90 days after 1515 receipt of complete documentation by the agency for review. If 1516 there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment 1517 within 180 days after receipt of complete documentation by the 1518

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1519 agency for review.

1520 (4) Any suspected criminal violation identified by the 1521 agency must be referred to the Medicaid Fraud Control Unit of 1522 the Office of the Attorney General for investigation. The agency 1523 and the Attorney General shall enter into a memorandum of 1524 understanding, which must include, but need not be limited to, a 1525 protocol for regularly sharing information and coordinating 1526 casework. The protocol must establish a procedure for the 1527 referral by the agency of cases involving suspected Medicaid 1528 fraud to the Medicaid Fraud Control Unit for investigation, and 1529 the return to the agency of those cases where investigation 1530 determines that administrative action by the agency is 1531 appropriate. Offices of the Medicaid program integrity program 1532 and the Medicaid Fraud Control Unit of the Department of Legal 1533 Affairs, shall, to the extent possible, be collocated. The 1534 agency and the Department of Legal Affairs shall periodically 1535 conduct joint training and other joint activities designed to 1536 increase communication and coordination in recovering 1537 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



1548 informed of the provider's current address. United States Postal 1549 Service proof of mailing or certified or registered mailing of 1550 such notice to the provider at the address shown on the provider 1551 enrollment file constitutes sufficient proof of notice. Any 1552 notice required to be given to the agency by this section must 1553 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

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1577 basis and the specific need for them are fully and properly 1578 documented in the recipient's medical record.

1580 The agency shall deny payment or require repayment for goods or 1581 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

1604 (9) A Medicaid provider shall retain medical, professional,1605 financial, and business records pertaining to services and goods

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1606 furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or 1607 1608 goods. The agency may investigate, review, or analyze such 1609 records, which must be made available during normal business 1610 hours. However, 24-hour notice must be provided if patient 1611 treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related 1612 1613 records. The authority of the agency to obtain Medicaid-related 1614 records from a provider is neither curtailed nor limited during 1615 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;

1633 (b) Until the Attorney General refers the case for criminal 1634 prosecution;

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1635 (c) Until 10 days after the complaint is determined without 1636 merit; or 1637 (d) At all times if the complaint or information is

1637 (d) At all times if the complaint or information is1638 otherwise protected by law.

1639 (13) The agency shall terminate participation of a Medicaid 1640 provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid 1641 1642 provider, if the provider or any principal, officer, director, 1643 agent, managing employee, or affiliated person of the provider, 1644 or any partner or shareholder having an ownership interest in 1645 the provider equal to 5 percent or greater, has been convicted 1646 of a criminal offense under federal law or the law of any state 1647 relating to the practice of the provider's profession, or a 1648 criminal offense listed under s. 408.809(4), s. 409.907(10), or 1649 s. 435.04(2). If the agency determines that the provider did not 1650 participate or acquiesce in the offense, termination will not be 1651 imposed. If the agency effects a termination under this 1652 subsection, the agency shall take final agency action.

1653 (14) If the provider has been suspended or terminated from 1654 participation in the Medicaid program or the Medicare program by 1655 the Federal Government or any state, the agency must immediately 1656 suspend or terminate, as appropriate, the provider's 1657 participation in this state's Medicaid program for a period no 1658 less than that imposed by the Federal Government or any other 1659 state, and may not enroll such provider in this state's Medicaid 1660 program while such foreign suspension or termination remains in 1661 effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's 1662 1663 Medicaid program if the provider participated or acquiesced in

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1664 any action for which any principal, officer, director, agent, 1665 managing employee, or affiliated person of the provider, or any 1666 partner or shareholder having an ownership interest in the 1667 provider equal to 5 percent or greater, was suspended or 1668 terminated from participating in the Medicaid program or the 1669 Medicare program by the Federal Government or any state. This 1670 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

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1693 provisions of state or federal laws, rules, or regulations; with 1694 provisions of the provider agreement between the agency and the 1695 provider; or with certifications found on claim forms or on 1696 transmittal forms for electronically submitted claims that are 1697 submitted by the provider or authorized representative, as such 1698 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;

(1) 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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1751 director, agent, managing employee, or affiliated person of the 1752 provider, or any partner or shareholder having an ownership 1753 interest in the provider equal to 5 percent or greater, in which 1754 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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1780 services that are inappropriate or of inferior quality as 1781 determined by competent peer judgment; each instance of 1782 knowingly submitting a materially false or erroneous Medicaid 1783 provider enrollment application, request for prior authorization 1784 for Medicaid services, drug exception request, or cost report; 1785 each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and 1786 1787 each false or erroneous Medicaid claim leading to an overpayment 1788 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 to3 years and that are monitored by the agency every 6 monthswhile in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

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1809 If a provider voluntarily relinquishes its Medicaid provider 1810 number or an associated license, or allows the associated 1811 licensure to expire after receiving written notice that the 1812 agency is conducting, or has conducted, an audit, survey, 1813 inspection, or investigation and that a sanction of suspension 1814 or termination will or would be imposed for noncompliance 1815 discovered as a result of the audit, survey, inspection, or 1816 investigation, the agency shall impose the sanction of 1817 termination for cause against the provider. The agency's 1818 termination with cause is subject to hearing rights as may be 1819 provided under chapter 120. The Secretary of Health Care 1820 Administration may make a determination that imposition of a 1821 sanction or disincentive is not in the best interest of the 1822 Medicaid program, in which case a sanction or disincentive may 1823 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.

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(d) The effect, if any, on the quality of medical care

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1838 provided to Medicaid recipients as a result of the acts of the 1839 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.

1847 The agency shall document the basis for all sanctioning actions 1848 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.

1859 (20) In making a determination of overpayment to a 1860 provider, the agency must use accepted and valid auditing, 1861 accounting, analytical, statistical, or peer-review methods, or 1862 combinations thereof. Appropriate statistical methods may 1863 include, but are not limited to, sampling and extension to the 1864 population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. 1865 Appropriate analytical methods may include, but are not limited 1866

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1867 to, reviews to determine variances between the quantities of products that a provider had on hand and available to be 1868 1869 purveyed to Medicaid recipients during the review period and the 1870 quantities of the same products paid for by the Medicaid program 1871 for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same 1872 1873 period. In meeting its burden of proof in any administrative or 1874 court proceeding, the agency may introduce the results of such 1875 statistical methods as evidence of overpayment.

1876 (21) When making a determination that an overpayment has 1877 occurred, the agency shall prepare and issue an audit report to 1878 the provider showing the calculation of overpayments. The 1879 agency's determination must be based solely upon information 1880 available to it before issuance of the audit report and, in the 1881 case of documentation obtained to substantiate claims for 1882 Medicaid reimbursement, based solely upon contemporaneous 1883 records. The agency may consider addenda or modifications to a 1884 note that was made contemporaneously with the patient care 1885 episode if the addenda or modifications are germane to the note.

1886 (22) The audit report, supported by agency work papers, 1887 showing an overpayment to a provider constitutes evidence of the 1888 overpayment. A provider may not present or elicit testimony on 1889 direct examination or cross-examination in any court or 1890 administrative proceeding, regarding the purchase or acquisition 1891 by any means of drugs, goods, or supplies; sales or divestment 1892 by any means of drugs, goods, or supplies; or inventory of 1893 drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, 1894 written inventory records, or other competent written 1895

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1896 documentary evidence maintained in the normal course of the 1897 provider's business. A provider may not present records to contest an overpayment or sanction unless such records are 1898 1899 contemporaneous and, if requested during the audit process, were 1900 furnished to the agency or its agent upon request. This 1901 limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of 1902 1903 addenda or modifications to a note if the addenda or 1904 modifications are made before notification of the audit, the 1905 addenda or modifications are germane to the note, and the note 1906 was made contemporaneously with a patient care episode. 1907 Notwithstanding the applicable rules of discovery, all 1908 documentation to be offered as evidence at an administrative 1909 hearing on a Medicaid overpayment or an administrative sanction 1910 must be exchanged by all parties at least 14 days before the 1911 administrative hearing or be excluded from consideration.

1912 (23) (a) In an audit, or investigation, or enforcement 1913 action taken for of a violation committed by a provider which is 1914 conducted pursuant to this section, the agency is entitled to recover all investigative and, legal costs incurred as a result 1915 1916 of such audit, investigation, or enforcement action. The costs 1917 associated with an investigation, audit, or enforcement action 1918 may include, but are not limited to, salaries and benefits of 1919 personnel, costs related to the time spent by an attorney and 1920 other personnel working on the case, and any other expenses 1921 incurred by the agency or contractor which are associated with 1922 the case, including any, and expert witness costs and attorney 1923 fees incurred on behalf of the agency or contractor if the 1924 agency's findings were not contested by the provider or, if

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1925 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.

1938 (24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection 1939 1940 (15), except paragraphs (15)(e) and (o), upon any provider or 1941 any principal, officer, director, agent, managing employee, or 1942 affiliated person of the provider who is regulated by another 1943 state entity, the agency shall notify that other entity of the 1944 imposition of the sanction within 5 business days. Such 1945 notification must include the provider's or person's name and license number and the specific reasons for sanction. 1946

(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

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1954 misrepresentation, abuse, or a crime did not occur, the payments 1955 withheld must be paid to the provider within 14 days after such 1956 determination. Amounts not paid within 14 days accrue interest 1957 at the rate of 10 percent per year, beginning after the 14th 1958 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.

1969 (d) The agency, upon entry of a final agency order, a 1970 judgment or order of a court of competent jurisdiction, or a 1971 stipulation or settlement, may collect the moneys owed by all 1972 means allowable by law, including, but not limited to, notifying 1973 any fiscal intermediary of Medicare benefits that the state has 1974 a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to 1975 1976 the state the sum claimed.

1977 (e) The agency may institute amnesty programs to allow
1978 Medicaid providers the opportunity to voluntarily repay
1979 overpayments. The agency may adopt rules to administer such
1980 programs.

1981 (26) The agency may impose administrative sanctions against1982 a Medicaid recipient, or the agency may seek any other remedy

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1983 provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has 1984 1985 engaged in solicitation in violation of s. 409.920 or that the 1986 recipient has otherwise abused the Medicaid program.

1987 (27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an 1989 overpayment to a Medicaid provider has occurred, the agency, 1990 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:

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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 2005 2006 and the Medicaid Fraud Control Unit of the Department of Legal 2007 Affairs may review a provider's Medicaid-related and non-2008 Medicaid-related records in order to determine the total output 2009 of a provider's practice to reconcile quantities of goods or 2010 services billed to Medicaid with quantities of goods or services 2011 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

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2042 (33) In accordance with federal law, Medicaid recipients 2043 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be 2044 limited, restricted, or suspended from Medicaid eligibility for 2045 a period not to exceed 1 year, as determined by the agency head 2046 or designee.

2047 (34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III 2049 refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of 2051 prescription refill claims for Schedule II and Schedule III 2052 pharmaceuticals if the agency or the Medicaid Fraud Control Unit 2053 determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative 2055 for whom the refill claim is submitted or was not prescribed by 2056 the recipient's medical provider or physician. Any such refill 2057 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 2065 recipients or their representatives through the distribution of 2066 explanations of benefits information about services reimbursed 2067 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



2070 entities for review or investigation, information on how to 2071 report criminal Medicaid fraud to the Medicaid Fraud Control 2072 Unit's toll-free hotline number, and information about the 2073 rewards available under s. 409.9203. The explanation of benefits 2074 may not be mailed for Medicaid independent laboratory services 2075 as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70. 2076

2077 (37) The agency shall post on its website a current list of 2078 each Medicaid provider, including any principal, officer, 2079 director, agent, managing employee, or affiliated person of the 2080 provider, or any partner or shareholder having an ownership 2081 interest in the provider equal to 5 percent or greater, who has 2082 been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a 2083 2084 variety of search parameters and provide for the creation of 2085 formatted lists that may be printed or imported into other 2086 applications, including spreadsheets. The agency shall update 2087 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 2093 health care fraud information and update the list at least 2095 biannually;

2096 (b) Develop a strategic plan to connect all databases that 2097 contain health care fraud information to facilitate the 2098 electronic exchange of health information between the agency,

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2099 the Department of Health, the Department of Law Enforcement, and 2100 the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and 2101 2102 specifications for the technical interface between state and 2103 federal health care fraud databases:

(c) Monitor innovations in health information technology, 2105 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 2116 2117 making of any false statement or false representation of a 2118 material fact, by commission or omission, in any claim submitted 2119 to the agency or its fiscal agent or a managed care plan for 2120 payment.

2121 2. Knowingly make, cause to be made, or aid and abet in the 2122 making of a claim for items or services that are not authorized 2123 to be reimbursed by the Medicaid program.

2124 3. Knowingly charge, solicit, accept, or receive anything 2125 of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally 2126 payable for an item or service provided to a Medicaid recipient 2127



2128 under the Medicaid program or knowingly fail to credit the 2129 agency or its fiscal agent for any payment received from a 2130 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.

2137 5. Knowingly solicit, offer, pay, or receive any 2138 remuneration, including any kickback, bribe, or rebate, directly 2139 or indirectly, overtly or covertly, in cash or in kind, in 2140 return for referring an individual to a person for the 2141 furnishing or arranging for the furnishing of any item or 2142 service for which payment may be made, in whole or in part, 2143 under the Medicaid program, or in return for obtaining, 2144 purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, 2145 2146 item, or service, for which payment may be made, in whole or in 2147 part, under the Medicaid program. This subparagraph does not 2148 apply to any discount, payment, waiver of payment, or payment 2149 practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or 2150 regulations adopted thereunder.

2151 6. Knowingly submit false or misleading information or
2152 statements to the Medicaid program for the purpose of being
2153 accepted as a Medicaid provider.

2154 7. Knowingly use or endeavor to use a Medicaid provider's 2155 identification number or a Medicaid recipient's identification 2156 number to make, cause to be made, or aid and abet in the making

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2157	of a claim for items or services that are not authorized to be
2158	reimbursed by the Medicaid program.
2159	Section 44. Subsection (1) of section 409.967, Florida
2160	Statutes, is amended to read:
2161	409.967 Managed care plan accountability
2162	(1) Beginning with the contract procurement process
2163	initiated during the 2023 calendar year, the agency shall
2164	establish a <u>6-year</u> 5 <del>-year</del> contract with each managed care plan
2165	selected through the procurement process described in s.
2166	409.966. A plan contract may not be renewed; however, the agency
2167	may extend the term of a plan contract to cover any delays
2168	during the transition to a new plan. The agency shall extend
2169	until December 31, 2024, the term of existing plan contracts
2170	awarded pursuant to the invitation to negotiate published in
2171	July 2017.
2172	Section 45. Paragraph (b) of subsection (5) of section
2173	409.973, Florida Statutes, is amended to read:
2174	409.973 Benefits
2175	(5) PROVISION OF DENTAL SERVICES.—
2176	(b) In the event the Legislature takes no action before
2177	July 1, 2017, with respect to the report findings required under
2178	subparagraph (a)2., the agency shall implement a statewide
2179	Medicaid prepaid dental health program for children and adults
2180	with a choice of at least two licensed dental managed care
2181	providers who must have substantial experience in providing
2182	dental care to Medicaid enrollees and children eligible for
2183	medical assistance under Title XXI of the Social Security Act
2184	and who meet all agency standards and requirements. To qualify
2185	as a provider under the prepaid dental health program, the

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2186 entity must be licensed as a prepaid limited health service 2187 organization under part I of chapter 636 or as a health 2188 maintenance organization under part I of chapter 641. The 2189 contracts for program providers shall be awarded through a 2190 competitive procurement process. Beginning with the contract 2191 procurement process initiated during the 2023 calendar year, the 2192 contracts must be for 6  $\frac{5}{2}$  years and may not be renewed; however, 2193 the agency may extend the term of a plan contract to cover 2194 delays during a transition to a new plan provider. The agency 2195 shall include in the contracts a medical loss ratio provision 2196 consistent with s. 409.967(4). The agency is authorized to seek 2197 any necessary state plan amendment or federal waiver to commence 2198 enrollment in the Medicaid prepaid dental health program no 2199 later than March 1, 2019. The agency shall extend until December 2200 31, 2024, the term of existing plan contracts awarded pursuant 2201 to the invitation to negotiate published in October 2017. 2202 Section 46. Subsection (6) of section 429.11, Florida 2203 Statutes, is amended to read: 2204 429.11 Initial application for license; provisional 2205 license.-2206 (6) In addition to the license categories available in s. 2207 408.808, a provisional license may be issued to an applicant 2208 making initial application for licensure or making application 2209 for a change of ownership. A provisional license shall be 2210 limited in duration to a specific period of time not to exceed 6 2211 months, as determined by the agency. 2212 Section 47. Subsection (9) of section 429.19, Florida 2213 Statutes, is amended to read: 429.19 Violations; imposition of administrative fines; 2214

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2215 grounds.-2216 <u>(9)</u>

(9) The agency shall develop and disseminate an annual list 2217 of all facilities sanctioned or fined for violations of state 2218 standards, the number and class of violations involved, the 2219 penalties imposed, and the current status of cases. The list 2220 shall be disseminated, at no charge, to the Department of 2221 Elderly Affairs, the Department of Health, the Department of 2222 Children and Families, the Agency for Persons with Disabilities, 2223 the area agencies on aging, the Florida Statewide Advocacy 2224 Council, the State Long-Term Care Ombudsman Program, and state 2225 and local ombudsman councils. The Department of Children and 2226 Families shall disseminate the list to service providers under 2227 contract to the department who are responsible for referring 2228 persons to a facility for residency. The agency may charge a fee 2229 commensurate with the cost of printing and postage to other 2230 interested parties requesting a copy of this list. This 2231 information may be provided electronically or through the 2232 agency's Internet site.

Section 48. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

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429.35 Maintenance of records; reports.-

2236 (2) Within 60 days after the date of an the biennial 2237 inspection conducted visit required under s. 408.811 or within 2238 30 days after the date of an any interim visit, the agency shall 2239 forward the results of the inspection to the local ombudsman 2240 council in the district where the facility is located; to at 2241 least one public library or, in the absence of a public library, 2242 the county seat in the county in which the inspected assisted 2243 living facility is located; and, when appropriate, to the

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2244 district Adult Services and Mental Health Program Offices.
2245 Section 49. Subsection (2) of section 429.905, Florida
2246 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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2273 respect to plumbing, heating, lighting, ventilation, and other 2274 building conditions, including adequate meeting space, to ensure 2275 the health, safety, and comfort of participants and protection 2276 from fire hazard. Such standards may not conflict with chapter 2277 553 and must be based upon the size of the structure and the 2278 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.

<u>(7)</u> Components of a comprehensive emergency management plan, developed in consultation with the Department of Health and the Division of Emergency Management.

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(2) Pursuant to this part, s. 408.811, and applicable



2302	rules, the agency may conduct an abbreviated biennial inspection
2303	of key quality-of-care standards, in lieu of a full inspection,
2304	of a center that has a record of good performance. However, the
2305	agency must conduct a full inspection of a center that has had
2306	one or more confirmed complaints within the licensure period
2307	immediately preceding the inspection or which has a serious
2308	problem identified during the abbreviated inspection. The agency
2309	shall develop the key quality-of-care standards, taking into
2310	consideration the comments and recommendations of provider
2311	groups. These standards shall be included in rules adopted by
2312	the agency.
2313	Section 51. Effective January 1, 2021, paragraph (e) of
2314	subsection (2) and paragraph (e) of subsection (3) of section
2315	627.6387, Florida Statutes, are amended to read:
2316	627.6387 Shared savings incentive program
2317	(2) As used in this section, the term:
2318	(e) "Shoppable health care service" means a lower-cost,
2319	high-quality nonemergency health care service for which a shared
2320	savings incentive is available for insureds under a health
2321	insurer's shared savings incentive program. Shoppable health
2322	care services may be provided within or outside this state and
2323	include, but are not limited to:
2324	1. Clinical laboratory services.
2325	2. Infusion therapy.
2326	3. Inpatient and outpatient surgical procedures.
2327	4. Obstetrical and gynecological services.
2328	5. Inpatient and outpatient nonsurgical diagnostic tests
2329	and procedures.
2330	6. Physical and occupational therapy services.

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7. Radiology and imaging services.

2332 8. Prescription drugs. 2333 9. Services provided through telehealth. 2334 10. Any additional services published by the Agency for 2335 Health Care Administration that have the most significant price 2336 variation pursuant to s. 408.05(3)(1). (3) A health insurer may offer a shared savings incentive 2337 2338 program to provide incentives to an insured when the insured 2339 obtains a shoppable health care service from the health 2340 insurer's shared savings list. An insured may not be required to 2341 participate in a shared savings incentive program. A health 2342 insurer that offers a shared savings incentive program must: 2343 (e) At least quarterly, credit or deposit the shared 2344 savings incentive amount to the insured's account as a return or 2345 reduction in premium, or credit the shared savings incentive 2346 amount to the insured's flexible spending account, health 2347 savings account, or health reimbursement account, or reward the 2348 insured directly with cash or a cash equivalent such that the amount does not constitute income to the insured. 2349 2350 Section 52. Effective January 1, 2021, paragraph (e) of 2351 subsection (2) and paragraph (e) of subsection (3) of section 2352 627.6648, Florida Statutes, are amended to read: 2353 627.6648 Shared savings incentive program.-2354 (2) As used in this section, the term: 2355 (e) "Shoppable health care service" means a lower-cost, 2356 high-quality nonemergency health care service for which a shared 2357 savings incentive is available for insureds under a health 2358 insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and 2359

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2360	include, but are not limited to:
2361	1. Clinical laboratory services.
2362	2. Infusion therapy.
2363	3. Inpatient and outpatient surgical procedures.
2364	4. Obstetrical and gynecological services.
2365	5. Inpatient and outpatient nonsurgical diagnostic tests
2366	and procedures.
2367	6. Physical and occupational therapy services.
2368	7. Radiology and imaging services.
2369	8. Prescription drugs.
2370	9. Services provided through telehealth.
2371	10. Any additional services published by the Agency for
2372	Health Care Administration that have the most significant price
2373	variation pursuant to s. 408.05(3)(1).
2374	(3) A health insurer may offer a shared savings incentive
2375	program to provide incentives to an insured when the insured
2376	obtains a shoppable health care service from the health
2377	insurer's shared savings list. An insured may not be required to
2378	participate in a shared savings incentive program. A health
2379	insurer that offers a shared savings incentive program must:
2380	(e) At least quarterly, credit or deposit the shared
2381	savings incentive amount to the insured's account as a return or
2382	reduction in premium, $rac{\partial r}{\partial r}$ credit the shared savings incentive
2383	amount to the insured's flexible spending account, health
2384	savings account, or health reimbursement account, or reward the
2385	insured directly with cash or a cash equivalent such that the
2386	amount does not constitute income to the insured.
2387	Section 53. Effective January 1, 2021, paragraph (e) of
2388	subsection (2) and paragraph (e) of subsection (3) of section

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2389	641.31076, Florida Statutes, are amended to read:
2390	641.31076 Shared savings incentive program
2391	(2) As used in this section, the term:
2392	(e) "Shoppable health care service" means a lower-cost,
2393	high-quality nonemergency health care service for which a shared
2394	savings incentive is available for subscribers under a health
2395	maintenance organization's shared savings incentive program.
2396	Shoppable health care services may be provided within or outside
2397	this state and include, but are not limited to:
2398	1. Clinical laboratory services.
2399	2. Infusion therapy.
2400	3. Inpatient and outpatient surgical procedures.
2401	4. Obstetrical and gynecological services.
2402	5. Inpatient and outpatient nonsurgical diagnostic tests
2403	and procedures.
2404	6. Physical and occupational therapy services.
2405	7. Radiology and imaging services.
2406	8. Prescription drugs.
2407	9. Services provided through telehealth.
2408	10. Any additional services published by the Agency for
2409	Health Care Administration that have the most significant price
2410	variation pursuant to s. 408.05(3)(1).
2411	(3) A health maintenance organization may offer a shared
2412	savings incentive program to provide incentives to a subscriber
2413	when the subscriber obtains a shoppable health care service from
2414	the health maintenance organization's shared savings list. A
2415	subscriber may not be required to participate in a shared
2416	savings incentive program. A health maintenance organization
2417	that offers a shared savings incentive program must:

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2418	(e) At least quarterly, credit or deposit the shared
2419	savings incentive amount to the subscriber's account as a return
2420	or reduction in premium, <del>or</del> credit the shared savings incentive
2421	amount to the subscriber's flexible spending account, health
2422	savings account, or health reimbursement account, or reward the
2423	subscriber directly with cash or a cash equivalent such that the
2424	amount does not constitute income to the subscriber.
2425	Section 54. Part I of chapter 483, Florida Statutes, is
2426	repealed, and part II and part III of that chapter are
2427	redesignated as part I and part II, respectively.
2428	Section 55. Paragraph (g) of subsection (3) of section
2429	20.43, Florida Statutes, is amended to read:
2430	20.43 Department of HealthThere is created a Department
2431	of Health.
2432	(3) The following divisions of the Department of Health are
2433	established:
2434	(g) Division of Medical Quality Assurance, which is
2435	responsible for the following boards and professions established
2436	within the division:
2437	1. The Board of Acupuncture, created under chapter 457.
2438	2. The Board of Medicine, created under chapter 458.
2439	3. The Board of Osteopathic Medicine, created under chapter
2440	459.
2441	4. The Board of Chiropractic Medicine, created under
2442	chapter 460.
2443	5. The Board of Podiatric Medicine, created under chapter
2444	461.
2445	6. Naturopathy, as provided under chapter 462.
2446	7. The Board of Optometry, created under chapter 463.

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2447	8. The Board of Nursing, created under part I of chapter
2448	464.
2449	9. Nursing assistants, as provided under part II of chapter
2450	464.
2451	10. The Board of Pharmacy, created under chapter 465.
2452	11. The Board of Dentistry, created under chapter 466.
2453	12. Midwifery, as provided under chapter 467.
2454	13. The Board of Speech-Language Pathology and Audiology,
2455	created under part I of chapter 468.
2456	14. The Board of Nursing Home Administrators, created under
2457	part II of chapter 468.
2458	15. The Board of Occupational Therapy, created under part
2459	III of chapter 468.
2460	16. Respiratory therapy, as provided under part V of
2461	chapter 468.
2462	17. Dietetics and nutrition practice, as provided under
2463	part X of chapter 468.
2464	18. The Board of Athletic Training, created under part XIII
2465	of chapter 468.
2466	19. The Board of Orthotists and Prosthetists, created under
2467	part XIV of chapter 468.
2468	20. Electrolysis, as provided under chapter 478.
2469	21. The Board of Massage Therapy, created under chapter
2470	480.
2471	22. The Board of Clinical Laboratory Personnel, created
2472	under <u>part I</u> of chapter 483.
2473	23. Medical physicists, as provided under <u>part II</u> <del>part III</del>
2474	of chapter 483.
2475	24. The Board of Opticianry, created under part I of

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2476 chapter 484. 2477 25. The Board of Hearing Aid Specialists, created under 2478 part II of chapter 484. 2479 26. The Board of Physical Therapy Practice, created under 2480 chapter 486. 2481 27. The Board of Psychology, created under chapter 490. 2482 28. School psychologists, as provided under chapter 490. 2483 29. The Board of Clinical Social Work, Marriage and Family 2484 Therapy, and Mental Health Counseling, created under chapter 2485 491. 2486 30. Emergency medical technicians and paramedics, as 2487 provided under part III of chapter 401. 2488 Section 56. Subsection (3) of section 381.0034, Florida 2489 Statutes, is amended to read: 2490 381.0034 Requirement for instruction on HIV and AIDS.-2491 (3) The department shall require, as a condition of granting a license under chapter 467 or part I part II of 2492 2493 chapter 483, that an applicant making initial application for 2494 licensure complete an educational course acceptable to the 2495 department on human immunodeficiency virus and acquired immune 2496 deficiency syndrome. Upon submission of an affidavit showing 2497 good cause, an applicant who has not taken a course at the time 2498 of licensure shall be allowed 6 months to complete this 2499 requirement. 2500 Section 57. Subsection (4) of section 456.001, Florida 2501 Statutes, is amended to read: 2502 456.001 Definitions.-As used in this chapter, the term: 2503 (4) "Health care practitioner" means any person licensed 2504 under chapter 457; chapter 458; chapter 459; chapter 460;

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2505 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; 2506 chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; 2507 2508 chapter 480; part I or part II part II or part III of chapter 2509 483; chapter 484; chapter 486; chapter 490; or chapter 491. 2510 Section 58. Paragraphs (h) and (i) of subsection (2) of section 456.057, Florida Statutes, are amended to read: 2511 2512 456.057 Ownership and control of patient records; report or 2513 copies of records to be furnished; disclosure of information.-2514 (2) As used in this section, the terms "records owner," 2515 "health care practitioner," and "health care practitioner's 2516 employer" do not include any of the following persons or 2517 entities; furthermore, the following persons or entities are not 2518 authorized to acquire or own medical records, but are authorized 2519 under the confidentiality and disclosure requirements of this 2520 section to maintain those documents required by the part or chapter under which they are licensed or regulated: 2521 2522 (h) Clinical laboratory personnel licensed under part I 2523 part II of chapter 483. 2524 (i) Medical physicists licensed under part II part III of 2525 chapter 483. 2526 Section 59. Paragraph (j) of subsection (1) of section 2527 456.076, Florida Statutes, is amended to read: 2528 456.076 Impaired practitioner programs.-2529 (1) As used in this section, the term: 2530 (j) "Practitioner" means a person licensed, registered, 2531 certified, or regulated by the department under part III of 2532 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; 2533

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2534 chapter 466; chapter 467; part I, part II, part III, part V, 2535 part X, part XIII, or part XIV of chapter 468; chapter 478; 2536 chapter 480; part I or part II part II or part III of chapter 2537 483; chapter 484; chapter 486; chapter 490; or chapter 491; or 2538 an applicant for a license, registration, or certification under 2539 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.-

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

2544 (b) "Telehealth provider" means any individual who provides 2545 health care and related services using telehealth and who is 2546 licensed or certified under s. 393.17; part III of chapter 401; 2547 chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; 2548 chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; 2549 part I, part III, part IV, part V, part X, part XIII, or part 2550 XIV of chapter 468; chapter 478; chapter 480; part I or part II 2551 part II or part III of chapter 483; chapter 484; chapter 486; 2552 chapter 490; or chapter 491; who is licensed under a multistate 2553 health care licensure compact of which Florida is a member 2554 state; or who is registered under and complies with subsection 2555 (4).

2556 Section 61. Except as otherwise expressly provided in this 2557 act and except for this section, which shall become effective 2558 upon this act becoming a law, this act shall take effect July 1, 2559 2020.

441796

2563 Delete everything before the enacting clause 2564 and insert: A bill to be entitled 2565 2566 An act relating to the Agency for Health Care 2567 Administration; amending s. 383.327, F.S.; requiring 2568 birth centers to report certain deaths and stillbirths 2569 to the agency; revising the frequency with which a 2570 certain report must be submitted to the agency; 2571 authorizing the agency to prescribe by rule the 2572 frequency with which such report is submitted; 2573 amending s. 395.003, F.S.; removing a requirement that 2574 specified information be listed on licenses for 2575 certain facilities; amending s. 395.1055, F.S.; 2576 requiring the agency to adopt specified rules related 2577 to ongoing quality improvement programs for certain cardiac programs; amending s. 395.602, F.S.; revising 2578 2579 the definition of the term "rural hospital"; repealing 2580 s. 395.7015, F.S., relating to an annual assessment on 2581 health care entities; amending s. 395.7016, F.S.; 2582 conforming a provision to changes made by the act; 2583 amending s. 400.19, F.S.; revising provisions 2584 requiring the agency to conduct licensure inspections 2585 of nursing homes; requiring the agency to conduct 2586 additional licensure surveys under certain 2587 circumstances; requiring the agency to assess a 2588 specified fine for such surveys; amending s. 400.462, 2589 F.S.; revising definitions; amending s. 400.464, F.S.; 2590 revising exemptions from licensure requirements for 2591 home health agencies; amending s. 400.471, F.S.;

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2592 revising provisions related to certain application 2593 requirements for home health agencies; amending s. 2594 400.492, F.S.; revising provisions related to services 2595 provided by home health agencies during an emergency; 2596 amending s. 400.506, F.S.; revising provisions related 2597 to licensure requirements for nurse registries; 2598 amending s. 400.509, F.S.; revising provisions related 2599 to the registration of certain service providers; 2600 amending s. 400.605, F.S.; removing a requirement that 2601 the agency conduct specified inspections of certain 2602 licensees; amending s. 400.60501, F.S.; deleting an 2603 obsolete date; removing a requirement that the agency 2604 develop a specified annual report; amending s. 2605 400.9905, F.S.; revising the definition of the term 2606 "clinic"; amending s. 400.991, F.S.; removing the 2607 option for health care clinics to file a surety bond 2608 under certain circumstances; amending s. 400.9935, 2609 F.S.; revising provisions related to the schedule of 2610 charges published and posted by certain clinics; 2611 specifying that urgent care centers are subject to 2612 such requirements; amending s. 408.033, F.S.; 2613 conforming a provision to changes made by the act; 2614 amending s. 408.05, F.S.; requiring the agency to 2615 publish by a specified date an annual report 2616 identifying certain health care services; amending s. 2617 408.061, F.S.; revising provisions requiring health 2618 care facilities to submit specified data to the 2619 agency; amending s. 408.0611, F.S.; removing a 2620 requirement that the agency annually report to the

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2621 Governor and the Legislature by a specified date on 2622 the progress of implementation of electronic 2623 prescribing, and instead, requiring the agency to 2624 annually publish such information on its website; 2625 amending s. 408.062, F.S.; removing requirements that 2626 the agency annually report specified information to 2627 the Governor and Legislature by a specified date and, 2628 instead, requiring the agency to annually publish such 2629 information on its website; amending s. 408.063, F.S.; 2630 removing a requirement that the agency publish certain 2631 annual reports; amending s. 408.803, F.S.; conforming 2632 a definition to changes made by the act; defining the 2633 term "low-risk provider"; amending ss. 408.802, 2634 408.820, 408.831, and 408.832, F.S.; conforming 2635 provisions to changes made by the act; amending s. 2636 408.806, F.S.; exempting certain providers from a 2637 specified inspection; amending s. 408.808, F.S.; 2638 authorizing the issuance of a provisional license to certain applicants; amending ss. 408.809 and 409.907, 2639 2640 F.S.; revising background screening requirements for 2641 certain licensees and providers; amending s. 408.811, 2642 F.S.; authorizing the agency to grant certain 2643 providers an exemption from a specified inspection 2644 under certain circumstances; authorizing the agency to 2645 adopt rules to grant waivers of certain inspections 2646 and allow for extended inspection periods under 2647 certain circumstances; requiring the agency to conduct 2648 unannounced licensure inspections of certain providers 2649 during a specified time period; providing that the



2650 agency may conduct regulatory compliance inspections of providers at any time; amending s. 408.821, F.S.; 2651 2652 revising provisions requiring licensees to have a 2653 specified plan; providing requirements for the 2654 submission of such plan; amending s. 408.909, F.S.; 2655 removing a requirement that the agency and Office of 2656 Insurance Regulation evaluate a specified program; 2657 amending s. 408.9091, F.S.; deleting a requirement 2658 that the agency and office submit a specified joint 2659 annual report to the Governor and Legislature; 2660 amending s. 409.905, F.S.; providing construction for 2661 a provision that requires the agency to discontinue 2662 its hospital retrospective review program under 2663 certain circumstances; providing legislative intent; 2664 amending 409.908, F.S.; revising provisions related to 2665 the prospective payment methodology for certain 2666 Medicaid provider reimbursements; repealing s. 19 of 2667 chapter 2019-116, Laws of Florida, relating to the 2668 abrogation of the scheduled expiration of an amendment 2669 to s. 408.908(23), F.S., and the scheduled reversion 2670 of the text of that subsection; amending s. 409.913, F.S.; revising the due date for a certain annual 2671 2672 report; deleting the requirement that certain agencies 2673 submit their annual reports jointly; providing that 2674 the agency or its contractor is entitled to recover 2675 certain costs and attorney fees related to audits, 2676 investigations, or enforcement actions conducted by 2677 the agency or its contractor; amending s. 409.920, 2678 F.S.; revising provisions related to prohibited



2679 referral practices in the Medicaid program; amending 2680 ss. 409.967 and 409.973, F.S.; revising the length of 2681 managed care plan contracts procured by the agency 2682 beginning during a specified timeframe; requiring the 2683 agency to extend the term of certain existing managed 2684 care plan contracts until a specified date; amending 2685 s. 429.11, F.S.; removing an authorization for the 2686 issuance of a provisional license to certain facilities; amending s. 429.19, F.S.; removing 2687 2688 requirements that the agency develop and disseminate a 2689 specified list and the Department of Children and 2690 Families disseminate such list to certain providers; 2691 amending ss. 429.35 and 429.905, F.S.; revising 2692 provisions requiring a biennial inspection cycle for 2693 specified facilities; amending s. 429.929, F.S.; 2694 revising provisions requiring a biennial inspection 2695 cycle for adult day care centers; amending ss. 2696 627.6387, 627.6648, and 641.31076, F.S.; revising the 2697 definition of the term "shoppable health care 2698 service"; revising duties of certain health insurers 2699 and health maintenance organizations; repealing part I 2700 of ch. 483, F.S., relating to the Florida Multiphasic 2701 Health Testing Center Law; redesignating parts II and 2702 III of ch. 483, F.S., as parts I and II, respectively; 2703 amending ss. 20.43, 381.0034, 456.001, 456.057, 2704 456.076, and 456.47, F.S.; conforming cross-2705 references; providing effective dates.

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LEGISLATIVE ACTION .

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Senate Comm: RCS 02/25/2020 House

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

Senate Amendment to Amendment (441796)

Delete line 113

4 and insert:

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deficiencies arising from separate surveys or investigations

House

Florida Senate - 2020 Bill No. CS for SB 1726



LEGISLATIVE ACTION

Senate 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

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(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.



11	(b)1. Base rate reimbursement for inpatient services under
12	a diagnosis-related group payment methodology shall be provided
13	in the General Appropriations Act.
14	2. Base rate reimbursement for outpatient services under an
15	enhanced ambulatory payment group methodology shall be provided
16	in the General Appropriations Act.
17	3. Prospective payment system reimbursement for nursing
18	home services shall be as provided in subsection (2) and in the
19	General Appropriations Act.
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21	===== DIRECTORY CLAUSE AMENDMENT ======
22	And the directory clause is amended as follows:
23	Delete line 1315
24	and insert:
25	409.908, Florida Statutes, is amended, and subsection (23) of
26	that section is reenacted, to read:
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28	=========== T I T L E A M E N D M E N T =================================
29	And the title is amended as follows:
30	Delete lines 2666 - 2669
31	and insert:
32	Medicaid provider reimbursements; reenacting s.
33	409.908(23), relating to reimbursement of Medicaid
34	providers for certain services; repealing s. 19 of
35	chapter 2019-116, Laws of Florida, relating to the
36	abrogation of the scheduled expiration of an amendment
37	to s. 409.908(23), F.S., and the scheduled reversion

House

Florida Senate - 2020 Bill No. CS for SB 1726

283312

LEGISLATIVE ACTION

Senate 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

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5 and insert:
6 subsection (2) and paragraphs (d) and (e) of subsection (3) of
7 section 627.6387, Florida Statutes, are amended to read:
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627.6387 Shared savings incentive program.-
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- (2) As used in this section, the term:
- (e) "Shoppable health care service" means a lower-cost,



11	high-quality nonemergency health care service for which a shared
12	savings incentive is available for insureds under a health
13	insurer's shared savings incentive program. Shoppable health
14	care services may be provided within or outside this state and
15	include, but are not limited to:
16	1. Clinical laboratory services.
17	2. Infusion therapy.
18	3. Inpatient and outpatient surgical procedures.
19	4. Obstetrical and gynecological services.
20	5. Inpatient and outpatient nonsurgical diagnostic tests
21	and procedures.
22	6. Physical and occupational therapy services.
23	7. Radiology and imaging services.
24	8. Prescription drugs.
25	9. Services provided through telehealth.
26	10. Any additional services published by the Agency for
27	Health Care Administration that have the most significant price
28	variation pursuant to s. 408.05(3)(1).
29	(3) A health insurer may offer a shared savings incentive
30	program to provide incentives to an insured when the insured
31	obtains a shoppable health care service from the health
32	insurer's shared savings list. An insured may not be required to
33	participate in a shared savings incentive program. A health
34	insurer that offers a shared savings incentive program must:
35	(d) Publish on a webpage easily accessible to insureds and
36	to applicants for insurance a list of shoppable health care
37	services and health care providers and the shared savings
38	incentive amount applicable for each service. A shared savings
39	incentive may not be less than $50$ $25$ percent of the savings

COMMITTEE AMENDMENT

Florida Senate - 2020 Bill No. CS for SB 1726



40 generated by the insured's participation in any shared savings 41 incentive offered by the health insurer. The baseline for the 42 savings calculation is the average in-network amount paid for 43 that service in the most recent 12-month period or some other 44 methodology established by the health insurer and approved by 45 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, <u>or reward the</u>
<u>insured directly with cash or a cash equivalent</u> 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.-

027.0040 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:

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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

69 and procedures.

70 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)(1).

(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:

83 (d) Publish on a webpage easily accessible to insureds and 84 to applicants for insurance a list of shoppable health care 85 services and health care providers and the shared savings 86 incentive amount applicable for each service. A shared savings 87 incentive may not be less than 50 25 percent of the savings generated by the insured's participation in any shared savings 88 89 incentive offered by the health insurer. The baseline for the 90 savings calculation is the average in-network amount paid for 91 that service in the most recent 12-month period or some other 92 methodology established by the health insurer and approved by 93 the office.

94 (e) At least quarterly, credit or deposit the shared 95 savings incentive amount to the insured's account as a return or 96 reduction in premium, or credit the shared savings incentive 97 amount to the insured's flexible spending account, health

603-04112-20



98	savings account, or health reimbursement account, or reward the
99	insured directly with cash or a cash equivalent such that the
100	amount does not constitute income to the insured.
101	Section 53. Effective January 1, 2021, paragraph (e) of
102	subsection (2) and paragraphs (d) and (e) of subsection (3) of
103	section 641.31076, Florida Statutes, are amended to read:
104	641.31076 Shared savings incentive program
105	(2) As used in this section, the term:
106	(e) "Shoppable health care service" means a lower-cost,
107	high-quality nonemergency health care service for which a shared
108	savings incentive is available for subscribers under a health
109	maintenance organization's shared savings incentive program.
110	Shoppable health care services may be provided within or outside
111	this state and include, but are not limited to:
112	1. Clinical laboratory services.
113	2. Infusion therapy.
114	3. Inpatient and outpatient surgical procedures.
115	4. Obstetrical and gynecological services.
116	5. Inpatient and outpatient nonsurgical diagnostic tests
117	and procedures.
118	6. Physical and occupational therapy services.
119	7. Radiology and imaging services.
120	8. Prescription drugs.
121	9. Services provided through telehealth.
122	10. Any additional services published by the Agency for
123	Health Care Administration that have the most significant price
124	variation pursuant to s. 408.05(3)(1).
125	(3) A health maintenance organization may offer a shared
126	savings incentive program to provide incentives to a subscriber

COMMITTEE AMENDMENT

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127 when the subscriber obtains a shoppable health care service from 128 the health maintenance organization's shared savings list. A 129 subscriber may not be required to participate in a shared 130 savings incentive program. A health maintenance organization 131 that offers a shared savings incentive program must:

132 (d) Publish on a webpage easily accessible to subscribers 133 and to applicants for coverage a list of shoppable health care 134 services and health care providers and the shared savings 135 incentive amount applicable for each service. A shared savings incentive may not be less than 50 25 percent of the savings 136 generated by the subscriber's participation in any shared 137 138 savings incentive offered by the health maintenance 139 organization. The baseline for the savings calculation is the 140 average in-network amount paid for that service in the most 141 recent 12-month period or some other methodology established by 142 the health maintenance organization and approved by the office.

incentives health insurers and health maintenance organizations may offer insureds or subscribers; revising duties of certain health insurers

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House

Florida Senate - 2020 Bill No. CS for SB 1726

588700

LEGISLATIVE ACTION

Senate Comm: WD 02/25/2020

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

Senate Amendment to Amendment (441796) (with title amendment)

is added to subsection (3) of that section, to read:

Delete lines 2315 - 2424

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8 627.6387 Shared savings incentive program.-
9 (2) As used in this section, the term:
10 (e) "Shoppable health care service" means a lower-cost,
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and insert:

Page 1 of 7

627.6387, Florida Statutes, are amended, and paragraph (g)



12 savings incentive is available for insureds under a health 13 insurer's shared savings incentive program. Shoppable health 14 care services may be provided within or outside this state and 15 include, but are not limited to: 16 1. Clinical laboratory services. 17 2. Infusion therapy. 18 3. Inpatient and outpatient surgical procedures. 19 4. Obstetrical and gynecological services. 20 5. Inpatient and outpatient nonsurgical diagnostic tests 21 and procedures.	red
<pre>14 care services may be provided within or outside this state and 15 include, but are not limited to: 16 1. Clinical laboratory services. 17 2. Infusion therapy. 18 3. Inpatient and outpatient surgical procedures. 19 4. Obstetrical and gynecological services. 20 5. Inpatient and outpatient nonsurgical diagnostic tests</pre>	
<pre>15 include, but are not limited to: 16 1. Clinical laboratory services. 17 2. Infusion therapy. 18 3. Inpatient and outpatient surgical procedures. 19 4. Obstetrical and gynecological services. 20 5. Inpatient and outpatient nonsurgical diagnostic tests</pre>	
<ol> <li>Clinical laboratory services.</li> <li>Infusion therapy.</li> <li>Inpatient and outpatient surgical procedures.</li> <li>Obstetrical and gynecological services.</li> <li>Inpatient and outpatient nonsurgical diagnostic tests</li> </ol>	l
<ol> <li>Infusion therapy.</li> <li>Inpatient and outpatient surgical procedures.</li> <li>Obstetrical and gynecological services.</li> <li>Inpatient and outpatient nonsurgical diagnostic tests</li> </ol>	
<ol> <li>Inpatient and outpatient surgical procedures.</li> <li>Obstetrical and gynecological services.</li> <li>Inpatient and outpatient nonsurgical diagnostic tests</li> </ol>	
<ol> <li>19</li> <li>4. Obstetrical and gynecological services.</li> <li>20</li> <li>5. Inpatient and outpatient nonsurgical diagnostic tests</li> </ol>	
20 5. Inpatient and outpatient nonsurgical diagnostic tests	
21 and procedures.	
22 6. Physical and occupational therapy services.	
23 7. Radiology and imaging services.	
24 8. Prescription drugs.	
9. Services provided through telehealth.	
26 <u>10. Any additional services published by the Agency for</u>	
27 Health Care Administration that have the most significant pric	e.
28 variation pursuant to s. 408.05(3)(1).	
29 (3) A health insurer may offer a shared savings incentive	<u>;</u>
30 program to provide incentives to an insured when the insured	
31 obtains a shoppable health care service from the health	
32 insurer's shared savings list. An insured may not be required	to
33 participate in a shared savings incentive program. A health	
34 insurer that offers a shared savings incentive program must:	
35 (e) At least quarterly, credit or deposit the shared	
36 savings incentive amount to the insured's account as a return	or
37 reduction in premium, <del>or</del> credit the shared savings incentive	
38 amount to the insured's flexible spending account, health	
39 savings account, or health reimbursement account, or reward th	le



40	insured directly with cash or a cash equivalent such that the
41	amount does not constitute income to the insured.
42	(g) If a health insurer offers cash or a cash equivalent,
43	provide the insured with a document approved by the commission
44	which explains the shared savings incentive in plain language
45	and which must include the following statement in 12-point bold
46	type:
47	
48	I UNDERSTAND THAT IF I RECEIVE CASH OR A CASH EQUIVALENT,
49	IT COUNTS AS INCOME TO ME AND MAY CAUSE ME TO OWE MORE INCOME
50	TAX. I ALSO UNDERSTAND THAT IF I RECEIVE INCOME-BASED BENEFITS,
51	THESE BENEFITS MAY BE AFFECTED IF I RECEIVE CASH OR A CASH
52	EQUIVALENT FROM THE SHARED SAVINGS PROGRAM.
53	Section 52. Effective January 1, 2021, paragraph (e) of
54	subsection (2) and paragraph (e) of subsection (3) of section
55	627.6648, Florida Statutes, are amended, and paragraph (g) is
56	added to subsection (3) of that section, to read:
57	627.6648 Shared savings incentive program
58	(2) As used in this section, the term:
59	(e) "Shoppable health care service" means a lower-cost,
60	high-quality nonemergency health care service for which a shared
61	savings incentive is available for insureds under a health
62	insurer's shared savings incentive program. Shoppable health
63	care services may be provided within or outside this state and
64	include, but are not limited to:
65	1. Clinical laboratory services.
66	2. Infusion therapy.
67	3. Inpatient and outpatient surgical procedures.
68	4. Obstetrical and gynecological services.

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69 5. Inpatient and outpatient nonsurgical diagnostic tests 70 and procedures. 6. Physical and occupational therapy services. 71 72 7. Radiology and imaging services. 73 8. Prescription drugs. 74 9. Services provided through telehealth. 75 10. Any additional services published by the Agency for 76 Health Care Administration that have the most significant price 77 variation pursuant to s. 408.05(3)(1). 78 (3) A health insurer may offer a shared savings incentive 79 program to provide incentives to an insured when the insured 80 obtains a shoppable health care service from the health 81 insurer's shared savings list. An insured may not be required to 82 participate in a shared savings incentive program. A health 83 insurer that offers a shared savings incentive program must: (e) At least quarterly, credit or deposit the shared 84 85 savings incentive amount to the insured's account as a return or 86 reduction in premium, or credit the shared savings incentive 87 amount to the insured's flexible spending account, health 88 savings account, or health reimbursement account, or reward the 89 insured directly with cash or a cash equivalent such that the amount does not constitute income to the insured. 90 91 (g) If a health insurer offers cash or a cash equivalent, provide the insured with a document approved by the commission 92 93 which explains the shared savings incentive in plain language 94 and which must include the following statement in 12-point bold 95 type: 96 97 I UNDERSTAND THAT IF I RECEIVE CASH OR A CASH EQUIVALENT,

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98 IT COUNTS AS INCOME TO ME AND MAY CAUSE ME TO OWE MORE INCOME 99 TAX. I ALSO UNDERSTAND THAT IF I RECEIVE INCOME-BASED BENEFITS, 100 THESE BENEFITS MAY BE AFFECTED IF I RECEIVE CASH OR A CASH 101 EQUIVALENT FROM THE SHARED SAVINGS PROGRAM. Section 53. Effective January 1, 2021, paragraph (e) of 102 103 subsection (2) and paragraph (e) of subsection (3) of section 104 641.31076, Florida Statutes, are amended, and paragraph (g) is 105 added to subsection (3) of that section, to read: 106 641.31076 Shared savings incentive program.-107 (2) As used in this section, the term: 108 (e) "Shoppable health care service" means a lower-cost, 109 high-quality nonemergency health care service for which a shared 110 savings incentive is available for subscribers under a health 111 maintenance organization's shared savings incentive program. 112 Shoppable health care services may be provided within or outside 113 this state and include, but are not limited to: 114 1. Clinical laboratory services. 115 2. Infusion therapy. 3. Inpatient and outpatient surgical procedures. 116 117 4. Obstetrical and gynecological services. 118 5. Inpatient and outpatient nonsurgical diagnostic tests 119 and procedures. 120 6. Physical and occupational therapy services. 121 7. Radiology and imaging services. 122 8. Prescription drugs. 123 9. Services provided through telehealth. 124 10. Any additional services published by the Agency for 125 Health Care Administration that have the most significant price 126 variation pursuant to s. 408.05(3)(1).

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127 (3) A health maintenance organization may offer a shared 128 savings incentive program to provide incentives to a subscriber 129 when the subscriber obtains a shoppable health care service from 130 the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared 131 132 savings incentive program. A health maintenance organization 133 that offers a shared savings incentive program must: 134 (e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return 135 136 or reduction in premium, or credit the shared savings incentive amount to the subscriber's flexible spending account, health 137 138 savings account, or health reimbursement account, or reward the 139 subscriber directly with cash or a cash equivalent such that the amount does not constitute income to the subscriber. 140 141 (g) If a health maintenance organization offers cash or a 142 cash equivalent, provide the subscriber with a document approved 143 by the commission which explains the shared savings incentive in 144 plain language and which must include the following statement in 145 12-point bold type: 146 147 I UNDERSTAND THAT IF I RECEIVE CASH OR A CASH EQUIVALENT, IT COUNTS AS INCOME TO ME AND MAY CAUSE ME 148 149 TO OWE MORE INCOME TAX. I ALSO UNDERSTAND THAT IF I 150 RECEIVE INCOME-BASED BENEFITS, THESE BENEFITS MAY BE 151 AFFECTED IF I RECEIVE CASH OR A CASH EQUIVALENT FROM 152 THE SHARED SAVINGS PROGRAM. 153 ========== T I T L E A M E N D M E N T ====== 154 155 And the title is amended as follows:

COMMITTEE AMENDMENT

Florida Senate - 2020 Bill No. CS for SB 1726



156 Delete line 2699 157 and insert: 158 and health maintenance organizations; requiring certain health insurers and health maintenance 159 organizations to provide to insureds and subscribers a 160 specified document under certain circumstances; 161 providing requirements for the content of the 162 163 document; repealing part I

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## **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 Am. 636790 (adopted) 1:09:44 PM S 1338 (cont.) 1:09:46 PM Appearances: Chris Nuland, Lobbyist, Florida Gastroenterologic Society (waives in support of the bill) 1:09:51 PM 1:10:10 PM Sen. Harrell Barney Bishop III, CEO, Florida Smart Justice Alliance (waives in support of the bill) 1:10:20 PM 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) Kevin Duane, Pharmacist, Small Business Pharmacies Aligned for Reform (speaks in support of the bill) 1:14:36 PM 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 Sen. Wright 1:25:10 PM Sen. Farmer 1:25:30 PM Sen. Harrell 1:26:52 PM Sen. Wright 1:28:14 PM 1:29:07 PM S 1338 (reported favorably) S 1544, Long-term Care 1:29:11 PM 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 Sen. Albritton 1:31:25 PM Sen. Rader 1:31:32 PM 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	ne 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 th	
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 2:02:51 PM	Sen. Diaz
	S 1094 (reported favorably)
2:03:13 PM 2:03:21 PM	S 1206, Applied Behavior Analysis Services Sen. Harrell
2:05:02 PM	Appearances: Dr. Steve Coleman, Public Policy Director, Florida Association for Behavior Analysis
(waives in sup) 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)
2:14:20 PM 2:15:27 PM	Sen. Harrell
2:16:13 PM	S 1206 (reported favorably)
2:16:13 PM	S 1200 (reported favorably) 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) Am. 617230
2:22:13 PM 2:22:18 PM	Sen. Rouson
2:22:44 PM	Sen. Harrell
2:22:44 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 2:28:13 PM	Am. 894626 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 2:32:11 PM	Sen. Hooper 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 2:38:40 PM	Sen. Harrell (Chair)
2:38:40 PM	S 1726, Agency for Health Care Administration 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 2:49:25 PM	Am. 283312 Sen. Rader
2:49:25 PM 2:50:24 PM	Sen. Bean
2:51:53 PM	Am. 283312 (withdrawn)

2:52:02 PM 2:52:12 PM 2:53:33 PM 2:54:14 PM 2:55:25 PM	Am. 588700 Sen. Rader Sen. Bean Am. 588700 (withdrawn) 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 sup	port 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