Tab 1	**CS/SB 414** by **CF, Perry (CO-INTRODUCERS) Boyd**; (Similar to CS/H 01349) Economic Self-sufficiency

Tab 2	**SB 606** by **Bean**; (Identical to H 01231) Domestic Violence

Tab 3	**CS/SB 700** by **HP, Rodriguez**; (Compare to CS/H 00247) Telehealth

645592	D	S	RCS	AHS, Rodriguez	Delete everything after	04/08 12:03 PM
520292	AA	S	RCS	AHS, Brodeur	btw L.108 - 109:	04/08 12:03 PM
607286	AA	S	RCS	AHS, Rodriguez	btw L.134 - 135:	04/08 12:03 PM
867884	AA	S	RCS	AHS, Rodriguez	Delete L.177 - 184.	04/08 12:03 PM
406586	A	S	OO	AHS, Brodeur	btw L.160 - 161:	04/08 12:03 PM
172640	A	S	OO	AHS, Rodriguez	Delete L.417 - 512.	04/08 12:03 PM

Tab 4	**CS/SB 894** by **HP, Diaz**; (Compare to CS/CS/H 00431) Physician Assistants

556138	A	S	RCS	AHS, Diaz	Delete L.104 - 575:	04/08 12:05 PM

Tab 5	**SB 900** by **Rodriguez**; (Compare to H 07039) Child Welfare

Tab 6	**CS/SB 1142** by **HP, Rodrigues**; (Similar to H 00721) Prohibited Acts by Health Care Practitioners

266254	A	S	RCS	AHS, Rodrigues	Delete L.101 - 116:	04/08 12:07 PM

Tab 7	**CS/SB 1242** by **HP, Book**; (Similar to CS/H 00905) Program of All-Inclusive Care for the Elderly

155134	A	S	RCS	AHS, Book	btw L.79 - 80:	04/08 12:09 PM

Tab 8	**CS/SB 1292** by **HP, Bean**; (Identical to CS/H 01057) Medicaid

Tab 9	**SB 1976** by **Brodeur**; (Similar to CS/H 01157) Freestanding Emergency Departments

880662	A	S	RCS	AHS, Brodeur	Delete L.95 - 138:	04/08 12:11 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Thursday, April 8, 2021
TIME: 9:00—11:00 a.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Rodriguez, Vice Chair; Senators Book, Brodeur, Burgess, Diaz, Farmer, Harrell, Jones, Rodrigues, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	PUBLIC TESTIMONY WILL BE RECEIVED FROM ROOM A3 AT THE DONALD L. TUCKER CIVIC CENTER, 505 W PENSACOLA STREET, TALLAHASSEE, FL 32301		
1	**CS/SB 414** Children, Families, and Elder Affairs / Perry (Similar CS/H 1349)	Economic Self-sufficiency; Revising the priority the early learning coalition is required to give children for participation in a school readiness program; requiring the Office of Early Learning within the Department of Education, in coordination with the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies, to conduct an analysis of certain assistance programs; requiring certain agencies to enter into a data-sharing agreement with certain entities and annually provide certain data by a specified date; requiring the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies to provide an annual report on the analysis to the Office of Early Learning by a specified date; providing for the scheduled expiration of the assistance program analysis project, etc. CF 03/23/2021 Fav/CS AHS 04/08/2021 Favorable AP	Favorable Yeas 11 Nays 0
2	**SB 606** Bean (Identical H 1231, Linked S 608)	Domestic Violence; Adding nonresidential outreach services to the list of services certified domestic violence centers must provide; revising the program content requirements for batterers' intervention programs; requiring the Department of Children and Families to certify and monitor batterers' intervention programs, etc. CF 03/16/2021 Favorable AHS 04/08/2021 Favorable AP	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**CS/SB 700** Health Policy / Rodriguez (Compare CS/H 247, CS/H 957, H 1477, S 660)	Telehealth; Requiring the Agency for Health Care Administration to reimburse the use of telehealth services under certain circumstances and subject to certain limitations; authorizing telehealth providers to prescribe specified controlled substances through telehealth under certain circumstances; authorizing registered pharmacy technicians to compound and dispense medicinal drugs under certain circumstances; exempting certain registered pharmacy technicians from specified prohibitions; providing additional long-acting medications pharmacists may administer under certain circumstances, etc. HP 02/17/2021 Fav/CS AHS 04/08/2021 Fav/CS AP	Fav/CS Yeas 9 Nays 0
4	**CS/SB 894** Health Policy / Diaz (Compare CS/CS/H 431, H 1299)	Physician Assistants; Deleting a limitation on the number of physician assistants a physician may supervise at one time; deleting a requirement that a physician assistant inform his or her patients that they have the right to see a physician before the physician assistant prescribes or dispenses a prescription; authorizing physician assistants to procure drugs and medical devices; authorizing physician assistants to bill for and receive direct payment for services they deliver, etc. HP 03/17/2021 Fav/CS AHS 04/08/2021 Fav/CS AP	Fav/CS Yeas 9 Nays 0
5	**SB 900** Rodriguez (Compare H 7039)	Child Welfare; Expanding the list of entities that have access to child abuse records; revising the authority of the Department of Children and Families to review reports for the purpose of employment screening; providing that licensed foster homes are the preferred supervised living arrangements for young adults; requiring assessments to be completed if the total number of children in a family foster home will exceed six, excluding the family's own children, before placement of a child in a family foster home, etc. CF 03/16/2021 Favorable AHS 04/08/2021 Favorable AP	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
6	**CS/SB 1142** Health Policy / Rodrigues (Similar H 721)	Prohibited Acts by Health Care Practitioners; Subjecting health care practitioners to discipline for making misleading, deceptive, or fraudulent representations related to their specialty designations; subjecting health care practitioners to discipline for failing to provide written or oral notice to patients of their specialty designation; requiring the Department of Health, instead of applicable health care practitioner boards, to enforce the written or oral notice requirement, etc. HP 03/17/2021 Fav/CS AHS 04/08/2021 Fav/CS AP	Fav/CS Yeas 9 Nays 0
7	**CS/SB 1242** Health Policy / Book (Similar CS/H 905)	Program of All-Inclusive Care for the Elderly; Authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve entities applying to deliver PACE services in the state; requiring notice of applications to be published in the Florida Administrative Register; requiring existing PACE organizations to meet specified requirements under certain circumstances; requiring the agency to oversee and monitor the PACE program and organizations, etc. HP 03/24/2021 Fav/CS AHS 04/08/2021 Fav/CS AP	Fav/CS Yeas 10 Nays 0
8	**CS/SB 1292** Health Policy / Bean (Identical CS/H 1057)	Medicaid; Deleting a requirement for the Agency for Health Care Administration to submit an annual report to the Legislature on the operation of the pharmaceutical expense assistance program; revising the method for determining prescribed drug provider reimbursements; requiring the agency to establish certain procedures related to prior authorization requests rather than prior consultation requests; revising the definitions of the terms “medical necessity” and “medically necessary” to provide an exception for behavior analysis services determinations, etc. HP 03/24/2021 Fav/CS AHS 04/08/2021 Favorable AP	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
9	**SB 1976** Brodeur (Similar CS/H 1157)	Freestanding Emergency Departments; Deleting an obsolete provision relating to a prohibition on new emergency departments located off the premises of licensed hospitals; prohibiting a freestanding emergency department from holding itself out to the public as an urgent care center; requiring a freestanding emergency department to clearly identify itself as a hospital emergency department using certain signage; requiring a freestanding emergency department to post signs in certain locations which contain specified statements; requiring health insurers to post certain information regarding appropriate use of emergency care services on their websites and update such information at least annually, etc. HP 03/24/2021 Favorable AHS 04/08/2021 Fav/CS AP	Fav/CS Yeas 10 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 414
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Perry and others
SUBJECT:	Economic Self-sufficiency
DATE:	April 7, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Cox	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 414 requires the Florida Office of Early Learning (OEL) to collaborate with the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies (UF) to conduct an analysis of certain federal and state programs. The analysis must review and analyze specified information and data. The bill requires each agency that is responsible for the administration of the program to enter into data-sharing agreements with OEL and UF, and provide a program services data file to UF, by specified dates.

The UF must provide the OEL with a report by June 30 each year which includes the results of the analysis. The OEL must submit the report to the Governor, President of the Senate, and Speaker of the House of Representatives within 30 days after receiving the report.

The bill amends the list of children who are given priority to participate in the School Readiness program. The bill also removes certain definitions applicable to the School Readiness program.

There is no anticipated fiscal impact on state or local government.

The bill is effective July 1, 2021.

II. Present Situation:

Several Florida government entities are responsible for administering federal and state funded programs to assist low-income families with food, housing, and other services which are summarized below.[1] Many of these programs are part of the Economic Self-Sufficiency Program that is administered by the Department of Children and Families (DCF) and designed to promote economic self-sufficient communities.[2]

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP) is a federal nutrition program, formerly known as "food stamps," that offers nutrition assistance to eligible, low-income individuals and families with funds to purchase eligible food and provides economic benefits to communities by reducing poverty and food insecurity.[3] The U.S. Department of Agriculture, Food and Nutrition Service (FNS) funds 100 percent of the SNAP benefit amount. However, FNS and states share the administrative costs of the program.[4]

Each state plan must meet the eligibility requirements and may not impose any additional eligibility requirements as a condition for participating in the program.[5] The Department of Children and Families (DCF) is responsible for determining an individual's eligibility to receive SNAP benefits.[6] The amount of benefits, or the allotment, a household qualifies for depends on the number of individuals in the household and the household's net income.[7] The program applies a gross income eligibility standard and excludes certain income from the calculation.[8] If the household's income is higher than the permitted amount, the household is not eligible for SNAP.[9] To calculate a household's allotment, 30 percent of its net income is subtracted from the maximum allotment for that household size.[10] As of November 2020, a total of 3,510,072 Floridians were participating in SNAP.[11]

The DCF reports that the FNS conducts annual reviews of SNAP to measure the accuracy of state eligibility and benefit determination through the assignment of error rates.[12] The SNAP

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[1] The DCF, *Agency Analysis for SB 414*, p. 2, January 11, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs) (hereinafter referred to as "The DCF Analysis").
[2] The DCF, *Program Overview*, available at https://myflfamilies.com/service-programs/access/overview.shtml (last visited March 31, 2021).
[3] USA Gov, *Food Assistance*, available at https://www.usa.gov/food-help (last visited March 31, 2021).
[4] U.S. Department of Agriculture, Food and Nutrition (FNS), *State Options Report: Supplemental Nutrition Assistance Program*, (11th ed.), Sept. 2013, *available at* http://www.fns.usda.gov/sites/default/files/snap/11-State_Options.pdf (last visited March 31, 2021).
[5] 7 U.S.C. §2014(b).
[6] *Id.* at p. 2.
[7] FNS, *SNAP Data Tables*, available at https://www.fns.usda.gov/snap/recipient/eligibility (last visited March 31, 2021).
[8] 7 U.S.C. §2014(b) and (c).
[9] *Id.*
[10] FNS, *SNAP Eligibility*, https://www.fns.usda.gov/snap/recipient/eligibility
(last visited March 31, 2021).
[11] FNS, *SNAP Data Tables*, available at https://fns-prod.azureedge.net/sites/default/files/resource-files/29SNAPcurrPP-3.pdf (last visited March 31, 2021).
[12] The DCF Analysis at p. 5.

Management Evaluation conducts ongoing assessments of the DCF's compliance with responsibilities for the administration of the program as required under federal law.[13]

Housing Choice Voucher Program

The Housing Choice Voucher Program (HCVP) "is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market."[14] The U.S. Department of Housing and Urban Development (HUD) oversees the HCVP,[15] but the program "is generally administered by State or local governmental entities called public housing agencies (PHAs)."[16] HUD provides funding to the PHAs, which then contract with a landlord to subsidize rent on behalf of the program participant.[17] Housing units receiving HCVP funding must meet and maintain certain housing quality standards.[18]

Generally, a family's income may not exceed 50 percent of the median income for the county or metropolitan area in which they live.[19] Seventy-five percent of the voucher provided to PHAs must be allocated to families whose income does not exceed 30 percent of the median income in the area.[20] If eligible, the PHA will provide a housing voucher if available or place the family on a waiting list.[21]

The Florida Housing Finance Corporation administers the Housing Choice Voucher Program.[22] On February 25, 2021, the HUD announced that it awarded Florida $281.5 million in grants to local communities for affordable housing.[23]

Temporary Cash Assistance Program

The DCF administers the Temporary Cash Assistance (TCA) program[24] which is intended to help families become self-supporting.[25] TCA is a state program that provides cash assistance to families with children under the age of 18 or under 19 for full time secondary school students that meet the specified requirements.[26] Applicants must meet a number of technical, income, and resource requirements.[27] The statute provides for cash assistance based upon the family size and

[13] *Id.*; 7 U.S.C. §275.5.
[14] The U.S. Department of Housing and Urban Development (HUD), *Housing Choice Vouchers Fact Sheet*, available at https://www.hud.gov/topics/housing_choice_voucher_program_section_8 (last visited March 24, 2021).
[15] See 42 U.S.C. s. 1437.
[16] 24 C.F.R. § 982.1.
[17] *Id.*
[18] See 24 C.F.R. § 982.401.
[19] The U.S. Department of Housing and Urban Development (HUD), *Housing Choice Vouchers Fact Sheet*, available at https://www.hud.gov/topics/housing_choice_voucher_program_section_8 (last visited March 24, 2021).
[20] *Id.*
[21] *Id.*
[22] The DCF Analysis at p. 2.
[23] The HUD, *Florida*, available at https://www.hud.gov/states/florida (last visited March 24, 2021).
[24] The DCF Analysis at p.2.
[25] DCF TCA.
[26] The DCF, *Temporary Cash Assistance (TCA)*, available at https://www.myflfamilies.com/service-programs/access/temporary-cash-assistance.shtml (last visited March 24, 2021) (hereinafter cited as "DCF TCA").
[27] Section 414.095, F.S.

amount the family has to pay, if any, for shelter.[28] The TCA program has no time limit for child only cases, but does have a set time limit of 48 months for adult recipients.[29]

Medicaid Program

Title XIX of the Social Security Act provides for medical assistance including eligible prescriptions for qualified individuals.[30] States that have an approved Medicaid state plan are eligible to receive a percentage of reimbursement of specified sums.[31] State plans must meet certain criteria that requires the state to contribute not less than 40 percent of the non-federal share of the expenses authorized under the plan and federal law.[32] States are required to provide information to permit monitoring of the program performance.[33] The Improper Payments Information Act[34] requires federal agencies to conduct annual reviews of the program to identify significant erroneous payments.[35] This is done by the Payment Error Rate Measurement (PERM) program conducting a 17-state three-year rotation process which means that each state is reviewed once every three years.[36]

The DCF is responsible for the Medicaid program eligibility requirements, and has authority to develop rules and the agreement with Social Security Administration.[37] Medicaid program payments are made only for services included in the program which are made on behalf of eligible individuals to qualified providers in accordance with federal and state law.[38] As of September 2020, Florida had enrolled 4,006,720 individuals in Medicaid and Children's Health Insurance Program.[39] When states are not under PERM review, the state is required to conduct Medicaid Eligibility Quality Control activities which are ordinarily based on the PERM findings to reduce or eliminate the identified deficiencies by the next PERM review.[40]

School Readiness Program

Part VI of ch. 1002, F.S., provides for Florida's School Readiness program. The OEL is the designated lead agency that must comply with the responsibilities under federal law, including the Child Care and Development Block Grant Trust Fund pursuant to 45 C.F.R. parts 98 and 99.[41] Early Learning Coalitions (ELC) are vested with powers and tasked with duties to operate

[28] Section 414.095(10), F.S.
[29] Benefits Application, *Florida Temporary Cash Assistance (TCA & TANF) Application Information*, available at http://benefitsapplication.com/program_info/FL/Temporary%20Cash%20Assistance#:~:text=Florida%20Temporary%20Cash%20Assistance%20%28TCA%20%26%20TANF%29%20Application,of%20the%20society%20and%20contribute%20to%20it%20positively (last visited March 24, 2021).
[30] 42 U.S.C. §1396a.
[31] 42 U.S.C. §1396b.
[32] 42 U.S.C. §1396a.
[33] 42 C.F.R. §431.954(a)(1).
[34] Pub. L. 107-300.
[35] 42 C.F.R. §431.954(a)(2).
[36] The DCF Analysis at p. 5.
[37] Section 409.963, F.S.
[38] *Id.*
[39] Medicaid.gov, *Medicaid & CHIP in Florida*, available at https://www.medicaid.gov/state-overviews/stateprofile.html?state=Florida (last visited March 24, 2021).
[40] The DCF Analysis at p. 5.
[41] Section 1002.82(1), F.S.

the program under Florida law including, in part, providing parents with information about available community resources, determining childrens' and providers' eligibility, and establishing a sliding fee scale.[42]

The ELC determines the sliding fee scale based on the family's income. "Family income" is defined as the combined gross income, whether earned or unearned, that is derived from any source by all family or household members who are 18 years of age or older who are currently residing together in the same dwelling unit with specified exclusions.[43]

"Earned income" means gross remuneration derived from work, professional service, or self-employment and includes commissions, bonuses, back pay awards, and the cash value of all remuneration paid in a medium other than cash.[44] "Unearned income" means income other than earned which includes but is not limited to, in part, documented alimony and child support received, social security and other specified benefits.[45]

The program provides assistance, for instance, with applying for various subsidies, negotiating discounts with child care providers, and identifying summer camp programs.[46]A child who is younger than 13 years old and who has a parent receiving temporary cash assistance under ch. 414, F.S., and subject to federal work requirements is given priority to participate in the program.[47] The OEL reports that approximately 62 percent of the 1.1 million children who are younger than six years old in Florida are enrolled in the School Readiness program.[48] Over 200,000 children received school readiness services from over 7,600 providers in the 2017-18 fiscal year.[49]

Preschool Development Grant

Florida's OEL is one of 20 states that receives the Preschool Development Birth to Five Renewal Grant (PDG-R).[50] It provides Florida with $13.4 million in funding each year for a total of three years.[51] The PDG-R will be used to improve Florida's programs and services to support young children and their families.[52] This is being done, in part, by analyzing data to determine whether the programs operate efficiently.[53]

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[42] Section 1002.84(3) and (7), F.S.
[43] Section 1002.81(8), F.S.
[44] Section 1002.81(6), F.S.
[45] Section 1002.81(15), F.S.
[46] Section 1002.92(3)(e) to (g), F.S.
[47] Section 1002.87(1), F.S.
[48] The OEL, *School Readiness*, available at http://www.floridaearlylearning.com/school-readiness (last visited March 24, 2021).
[49] *Id.*
[50] The OEL, *Preschool Development Birth through Five Renewal Grant (PDG-R)*, available at http://www.floridaearlylearning.com/statewide-initiatives/preschool-development-grant-birth-through-five (last visited March 24, 2021) (hereinafter cited as "OEL PDG-R").
[51] *Id.*
[52] Florida's State Advisory Council, *Florida Early Childhood Strategic Plan*, p. iii, July 2019, available at http://www.floridaearlylearning.com/Content/Uploads/floridaearlylearning.com/images/Strategic_Plan_FINAL_FINAL_10.16.19.pdf (last visited March 24, 2021).
[53] OEL PDG-R.

The OEL collaborates with the UF to perform certain work required under the Strategic Plan which drives how the grant funds will be used.[54] UF is currently conducting an analysis of state programs to determine needs and an unduplicated count of children within the programs and developing reporting capacity of the current needs assessment portal (ECENA).[55]

III. Effect of Proposed Changes:

The bill requires the OEL, in coordination with UF, to analyze the following programs:

- Supplemental Nutrition Assistance Program;[56]
- Temporary Cash Assistance program;[57]
- Medicaid program;[58]
- School Readiness program;[59] and
- Housing Choice Voucher Program.[60]

The analysis must include the following information:

- The program eligibility criteria;
- The manner by which each program establishes and documents eligibility and disbursement policies;
- The frequency of eligibility determinations;
- The clarity of both written and verbal communication in which eligibility requirements are conveyed to current and potential program recipients;
- Opportunities for improving service efficiency and efficacy; and
- The number and size of families receiving multiple program services compared to all eligible families.

The UF must develop participation profiles based on the number of families receiving multiple program services including the family composition and the most frequent program services or combination of services the families are receiving in each county or region.

The UF must provide a report with the results of the analysis to the OEL by June 30 of each year, and within 30 days of receiving the report, the OEL must submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The bill provides for a sunset clause of June 30, 2023.

The bill removes the definitions of "earned income" and "unearned income" in s. 1002.81, F.S. This means that the statute will no longer specify how family income is calculated for purposes of eligibility for the School Readiness program, allowing the OEL to establish income eligibility

[54] *Id.*; University of Florida, *Preschool Development Grant University of Florida Anita Zucker Center for Excellence in Early Childhood Studies Scope of Work*, available at https://education.ufl.edu/research/files/2019/06/Preschool-Development-Grant_07-31-19.pdf (last visited March 24, 2021) (hereinafter cited as "UF Scope of Work").
[55] UF Scope of Work.
[56] 7 U.S.C. ss. 2011 et seq.
[57] Section 414.095, F.S.
[58] Section 409.963, F.S.
[59] Ch. 1002, F.S.
[60] 42 U.S.C. s. 1437f.

requirements for the school readiness program[61] without the limitations included in the definitions and, in particular, will permit the OEL to exclude stimulus funds received by families that may otherwise cause them to be deemed ineligible for the program. Income eligibility requirements must be established in accordance with s. 1002.87, F.S., and federal law.[62]

The bill amends the list of children who receive priority to participate in the School Readiness program to include a parent who has an Intensive Service Account or an Individual Training Account under s. 445.009, F.S.[63]

The bill is effective July 1, 2021.

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:

None.

[61] Section 1002.82(2)(z), F.S.
[62] *See* 45 C.F.R. § 98.21.
[63] These accounts are used to provide funds for intensive services and training provided pursuant to Pub. L. No. 113-128. Individual Training Accounts must be expended on programs that train people to enter high-wage occupations.

C. Government Sector Impact:

The OEL will absorb costs for the additional responsibilities related to audit requests.[64]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 1002.81 and 1002.87.

The bill creates an undesignated section of law.

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 Children, Families, and Elder Affairs on March 23, 2021:
The committee substitute:

- Removes the requirement for the Auditor General to conduct an audit once every three years of certain state and federally funded programs;
- Provides for the OEL in collaboration with the UF to conduct an analysis of the state and federally funded programs annually;
- Removes the requirement to analyze the data related to families who claim the Earned Income Tax Credit;
- Provides the UF to develop participation profiles based on specified data;
- Requires the UF to provide the OEL with a report of the data results by a specified date each year, and the OEL to submit a copy of the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives within 30 days of receipt;
- Provides for a sunset clause of June 30, 2023;
- Removes the definitions of "earned income" and "unearned income" from s. 1002.81, F.S.; and
- Expands the list of children who receive priority to participate in the School Readiness program.

B. Amendments:

None.

[64] The DOE Analysis at p. 4.

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: March 24, 2021

I respectfully request that **Senate Bill #414**, relating to Economic Self-sufficiency, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

W. Keith Perry

Senator Keith Perry
Florida Senate, District 8

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

4/4
Bill Number (if applicable)

Topic Economic Self-Sufficiency

Amendment Barcode (if applicable)

Name Michele Watson

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Address 1126 Lee Avenue Suite B
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Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Children's Council

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

By the Committee on Children, Families, and Elder Affairs; and Senators Perry and Boyd

586-03270-21 2021414c1

A bill to be entitled

An act relating to economic self-sufficiency; amending s. 1002.81, F.S.; deleting obsolete language; amending s. 1002.87, F.S.; revising the priority the early learning coalition is required to give children for participation in a school readiness program; requiring the Office of Early Learning within the Department of Education, in coordination with the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies, to conduct an analysis of certain assistance programs; providing requirements for the analysis; requiring certain agencies to enter into a data-sharing agreement with certain entities and annually provide certain data by a specified date; requiring the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies to provide an annual report on the analysis to the Office of Early Learning by a specified date; requiring the Office of Early Learning to submit the annual report to the Governor and the Legislature within a certain timeframe; providing for the scheduled expiration of the assistance program analysis project; providing an effective date.

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

Section 1. Subsections (6) and (15) of section 1002.81, Florida Statutes, are amended to read:

1002.81 Definitions.—Consistent with the requirements of 45

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

586-03270-21 2021414c1

C.F.R. parts 98 and 99 and as used in this part, the term:

~~(6) "Earned income" means gross remuneration derived from work, professional service, or self-employment. The term includes commissions, bonuses, back pay awards, and the cash value of all remuneration paid in a medium other than cash.~~

~~(15) "Unearned income" means income other than earned income. The term includes, but is not limited to:~~

~~(a) Documented alimony and child support received.~~

~~(b) Social security benefits.~~

~~(c) Supplemental security income benefits.~~

~~(d) Workers' compensation benefits.~~

~~(e) Reemployment assistance or unemployment compensation benefits.~~

~~(f) Veterans' benefits.~~

~~(g) Retirement benefits.~~

~~(h) Temporary cash assistance under chapter 414.~~

Section 2. Paragraph (a) of subsection (1) of section 1002.87, Florida Statutes, is amended to read:

1002.87 School readiness program; eligibility and enrollment.—

(1) Each early learning coalition shall give priority for participation in the school readiness program as follows:

(a) Priority shall be given first to a child younger than 13 years of age from a family that includes a parent who is receiving temporary cash assistance under chapter 414 and subject to the federal work requirements or a parent who has an Intensive Service Account or an Individual Training Account under s. 445.009.

Section 3. (1) The Office of Early Learning within the

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Department of Education shall, in coordination with the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies, conduct an analysis of, at a minimum, recipients of the Supplemental Nutrition Assistance Program established under 7 U.S.C. ss. 2011 et seq., the temporary cash assistance program established under chapter 414, Florida Statutes, the Medicaid program under s. 409.963, Florida Statutes, the school readiness program under part VI of chapter 1002, Florida Statutes, and the housing choice voucher program established under 42 U.S.C. s. 1437.

(2) The analysis must include a review of eligibility criteria, the manner in which each program establishes and documents eligibility and disbursement policies, the frequency of eligibility determinations, and the number of families receiving multiple program services as compared to the total number of eligible families.

(3) As part of the analysis, the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies shall develop participant profiles based on the number of families receiving multiple program services which include family composition and the most frequent program services or combination of services families are accessing in each county or geographic region.

(4) Each agency responsible for the administration of a program that is required to be analyzed under subsection (1) shall enter into a data-sharing agreement with the Office of Early Learning and the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies by September 1, 2021. Upon execution of the data-sharing agreement, each such agency,

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by November 1, 2021, shall submit a program services data file to the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies which contains program service data from the preceding 10 federal fiscal years, as available. By November 1, 2022, and each November 1 thereafter, each such agency shall submit a supplemental data file to the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies containing program service data from the preceding federal fiscal year.

(5) By each June 30, the University of Florida Anita Zucker Center for Excellence in Early Childhood Studies shall provide a report to the Office of Early Learning based on the results of the analysis required by this section.

(6) Within 30 days after receiving the report, the Office of Early Learning shall submit it to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(7) This section shall expire on June 30, 2023, unless reviewed and reenacted by the Legislature before that date.

Section 4. This act shall take effect July 1, 2021.

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 606
INTRODUCER:	Senator Bean
SUBJECT:	Domestic Violence
DATE:	April 7, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Cox	CF	**Favorable**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.			AP	

I. Summary:

SB 606 amends current law to recognize that domestic violence is a significant public health threat that has adverse physical, emotional, and financial impact on Florida families. The bill also amends current law to add nonresidential outreach services to the list of minimum services a certified domestic violence center must provide. It amends current law to require certified domestic violence centers to obtain public and private funding in an amount of at least 25 percent of the amount of funding the center receives from the Domestic Violence Trust Fund and permits certified domestic violence centers to carry forward, from one fiscal year to the next, unexpended state funds in a cumulative amount not to exceed eight percent of their total contract with the DCF.

The bill revives, reenacts, and amends s. 741.327, F.S., to authorize the DCF to certify and monitor Batterers' Intervention Programs (BIPs). The bill also amends current law to permit certified BIPs to use a cognitive behavioral model or a psychoeducational model in its program content.

The bill has an insignificant fiscal impact on state government.

The bill has an effective date of July 1, 2021.

II. Present Situation:

Background

Domestic Violence

Domestic violence is a pattern of behavior, violence, or threats of violence that a person uses to gain power and control over a current or former intimate partner.[1] The use of threats, intimidation, isolation, and using children as pawns are examples of the tactics domestic violence perpetrators use against victims.[2]

Florida law defines domestic violence as any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.[3] A family or household member includes spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.[4]

In 2018, a total of 104,914 domestic violence offenses were reported to law enforcement.[5] That same year, 215 individuals died as a result of domestic violence homicide, which equals approximately 19 percent of all homicides in Florida.[6] Law enforcement made 64,573 arrests for domestic violence related crimes.[7]

Domestic Violence Program

The Legislature acknowledges that certain perpetrators and victims of domestic violence are in need of treatment and rehabilitation.[8] It is the intent of the Legislature to assist in the development of domestic violence centers for the victims of domestic violence and to provide a place where the parties involved may be separated until they can be properly assisted.[9]

The Domestic Violence Program protects adults and their children from domestic violence and helps survivors develop ways to avoid further harm. The Department of Children and Families (DCF) is statutorily responsible for the statewide domestic violence program and is responsible

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[1] Florida Coalition Against Domestic Violence, *Leading Florida Higher, Lifting Survivors Upward, Florida's Commitment to Ending Domestic Violence and Saving Lives*, p. 3, available at https://www.myflfamilies.com/service-programs/domestic-violence/docs/2019%20Annual%20%20Report.pdf (last visited April 1, 2021).
[2] *Id*.
[3] Section 741.28(1), F.S.
[4] Section 741.28(2), F.S.
[5] Florida Coalition Against Domestic Violence, *Leading Florida Higher, Lifting Survivors Upward, Florida's Commitment to Ending Domestic Violence and Saving Lives*, p. 4, available at https://www.myflfamilies.com/service-programs/domestic-violence/docs/2019%20Annual%20%20Report.pdf (last visited April 1, 2021).
[6] *Id*.
[7] *Id*.
[8] Section 39.901, F.S.
[9] *Id*.

for performing specified duties and functions with respect to domestic violence. Section 39.903, F.S., requires the DCF to:

- Operate the domestic violence program and coordinate and administer statewide activities;
- Receive and approve or reject applications for initial certification of domestic violence centers, and annually renew the certification thereafter;
- Inspect the premises of domestic violence centers that are applying for an initial certification or facing potential suspension or revocation of certification;
- Promote the involvement of certified domestic violence centers in the coordination, development, and planning of domestic violence programming in the circuits;
- Coordinate with state agencies that have health, education, or criminal justice responsibilities;
- Cooperate with, assist in and participate in, programs of other properly qualified state agencies;
- Contract with an entity or entities for the delivery and management of services for the state's domestic violence program if it is in the best interest of the state;
- Consider applications from certified domestic violence centers for capital improvement grants and award those grants; and
- Adopt rules to administer this section.

Domestic Violence Centers

Domestic violence centers provide services to survivors of domestic violence.[10] Florida has 41 certified domestic violence centers. The certified domestic violence centers provide crisis counseling and support services to victims of domestic violence and their children.[11]

The certified domestic violence centers provide all of the following services free of charge:

- Emergency shelter.
- A 24-hour crisis and information hotline.
- Safety planning.
- Counseling, case management, and child assessments.
- Education for community awareness.
- Training for law enforcement and other professionals.
- Other ancillary services such as relocation assistance, daycare, and transitional housing.[12]

Certified domestic violence centers also provide nonresidential outreach services.

Domestic violence centers must be certified by the DCF in order to receive state funding.[13] The DCF sets criteria for certification and minimum standards to ensure the health and safety of clients served.[14] To be eligible for certification as a domestic violence center, an applicant must

[10] Section 39.902(2), F.S.; Rule 65H-1.011, F.A.C.
[11] Department of Children and Families, *Domestic Violence Overview*, available at https://www.myflfamilies.com/service-programs/domestic-violence/overview.shtml (last visited April 1, 2021).
[12] *Id*.
[13] Section 39.905(6)(a), F.S.
[14] Sections 39.903(9) and 39.905(1), F.S.; Rule 65H-1, F.A.C.

apply to the DCF and be a not-for-profit entity.[15] A domestic violence center's primary mission must be to provide services to survivors of domestic violence.

An applicant may seek certification to serve an area that has an existing certified domestic violence center; however, the applicant must show there is an unmet need in the area.[16] One of the minimum criteria that an applicant must meet is that the domestic violence center has been providing services to survivors for 18 consecutive months, including 12 months as an emergency shelter.[17] After the DCF certifies a domestic violence center, the certification is good for one year and automatically expires on June 30. If there is a favorable report from the DCF, it will annually renew a domestic violence center's certification.[18]

Certified domestic violence centers employ staff and rely on volunteers to provide services to survivors. A domestic violence advocate is an employee or a volunteer of a certified center who has 30 hours of training in assisting victims of domestic violence and is an employee or volunteer for a program for survivors of domestic violence whose primary purpose is the rendering of advice, counseling, or assistance to survivors of domestic violence.[19] A volunteer is an unpaid staff member who provides direct or indirect services for a certified domestic violence center. All employees and volunteers receive some degree of training on domestic violence.[20]

Section 39.905(6)(b), F.S., requires certified domestic violence centers to obtain at least 25 percent of funding from one or more local, municipal or county sources, public or private. Contributions in kind may be counted toward the 25 percent local funding requirement. When this provision was enacted, centers received funding from the Domestic Violence Trust Fund established in s. 741.01, F.S.

Section 39.905, F.S., currently does not permit certified domestic violence centers to carry forward documented unexpended state funds from one fiscal year to the next. The current annual funding model requires certified domestic violence centers to spend all funds within the fiscal year, potentially creating an incentive for inappropriate use of funds.

Batterers' Intervention Program

Batterer intervention programs (BIPs) emerged in the United States in the late 1970's as one component of the social response to domestic violence.[21] BIPs are designed to address the root

[15] The DCF, *Domestic Violence Center, Application for Certification, Form CF613*, p. 3, January 2015, available at https://www.myflfamilies.com/service-programs/domestic-violence/docs/CF-613_Application-for-Certification.pdf (last visited March 15, 2021).
[16] Section 39.905(1)(i), F.S.; Rule 65H-1.012, F.A.C.
[17] Section 39.905(1)(h), F.S.; Rule 65H-1.012, F.A.C.
[18] Section 39.905(3), F.S.; Rule 65H-1.012, F.A.C.
[19] Section 90.5036. F.S.; R. 65H-1.011(9), F.A.C., states "'domestic violence advocate' means an employee or volunteer of a certified domestic violence center who: provides direct services to individuals victimized by domestic violence; has received 30 hours of domestic violence core competency training; and, has been identified by the domestic violence center as an individual who may assert a claim to privileged communications with domestic violence victims under section 39.905, F.S."
[20] Rule 65H-1.011(17), F.A.C., states "'volunteer' means unpaid staff members trained in the dynamics of domestic violence who provide direct and indirect services to those seeking and receiving services from a domestic violence center".
[21] Battered Women's Justice Project, *Current Research on Batterer Intervention Programs and Implications for Policy*, p. 1, December 2017, available at https://www.bwjp.org/assets/batterer-intervention-paper-final-2018.pdf (last visited April 1, 2021) (hereinafter cited as "Research on BIP and Policy Implications").

cause of domestic violence and deter participants from committing acts of domestic violence in the future.[22]

Alleged perpetrators may be ordered, and in some cases must be ordered, by the court to a BIP. An alleged perpetrator may come to the attention of the court after a petition for protection against domestic violence is filed against him or her. This petition may be filed by any person who either is the victim of domestic violence or has reasonable cause to believe he or she is in imminent danger of becoming the victim of domestic violence.[23] The person can file a petition against a current or former spouse, any person related by blood or marriage, any person who is or was residing within a single dwelling unit, or is a person with whom the petitioner had a child.[24] When it appears to the court that the petitioner either is the victim of domestic violence or has reasonable cause to believe he or she is in imminent danger, the court may order the alleged perpetrator to participate in treatment, intervention, or counseling services.[25] When the court orders the alleged perpetrator to participate in a BIP, the court must provide a list of batterers' intervention programs.[26] If a person is found guilty of, has adjudication withheld, or pleads no contest[27] to an offense defined as domestic violence, the court must order the defendant to complete a BIP as a condition of probation.[28]

Section 741.32, F.S., recognizes the need for standardized programming for domestic violence BIPs, but does not reference any state agency to certify and monitor BIPs to ensure compliance with program standards. The DCF performed this role from 2001 through 2012 under s. 741.325, F.S. However, the General Appropriations Act of 2011-2012[29] eliminated funding for the DCF's BIP certification staff, and the Legislature repealed s. 741.32(2), F.S., which removed the DCF's Office of Certification and Monitoring of Batterers' Intervention and repealed the statutory requirement that batterers' intervention programs be certified by the DCF. There has been no state certification or monitoring of BIPs since 2012.

Judges, domestic violence advocates, prosecutors, survivors, and BIP providers have raised concerns that lack of state certification and monitoring has adversely impacted the overall quality of BIPs in their communities.[30]

Section 741.325, F.S., sets requirements for BIPs to meet, including that the:

- Primary purpose of the program must be the safety of the victim and children, if present;
- Batterer must be held accountable for acts of domestic violence;
- Program must be at least 29 weeks in length and include 24 weekly sessions, plus appropriate intake, assessment, and orientation programming;

[22] *Id.* at pp. 3, 6.
[23] Section 741.30(1)(a), F.S.
[24] Section 741.30(3)(f), F.S.
[25] Section 741.30(6)(a)5., F.S.
[26] *Id*.
[27] A no contest plea (also referred to as a nolo contendere plea) means a criminal defendant will not dispute the charge.
[28] Section 741.281, F.S.
[29] Chapter 2011-69, Laws of Florida.
[30] The DCF, *Agency Analysis for SB 606*, p. 2, January 29, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs) (hereinafter cited as "The DCF Analysis").

- Program content must be based on a psychoeducational model that addresses tactics of power and control by one person over another; and
- Program shall be funded by user fees paid by the batterers who attend the program, which allows them to take responsibility for their acts of violence.[31]

Florida is one of 47 states that has BIP laws that require adherence to a psychoeducational type of model, referred to as the Duluth model.[32] The Duluth model, named after a city in Minnesota where it was developed, is a coordinated service approach that requires batterers to acknowledge the various forms of violence they use to exert power and control over their intimate partners.[33]

While the Duluth model remains one of the primary BIP models today, BIP programs also utilize or incorporate a cognitive behavioral model, which has been more recently recognized as effective in changing batterer behavior.[34]

III. Effect of Proposed Changes:

The bill updates the legislative intent expressed in s. 39.901, F.S., to reflect the current s. 741.28, F.S., statutory definition of domestic violence which includes as victims spouses, ex-spouses, and those persons who share a child in common. The new language recognizes that domestic violence is a significant public health threat that has adverse physical, emotional, and financial impact on Florida families. It also recognizes the critical need for victims and their dependents to have access to emergency shelter and crisis intervention services to help them live free of violence.

The bill amends language to recognize that the DCF certifies and monitors domestic violence centers to ensure statewide consistency and effective service provision. This new language reflects the 2020 amendments to ch. 39, F.S., that removed references to the Florida Coalition Against Domestic Violence and named the DCF as the agency responsible for certifying and monitoring domestic violence centers.

The bill amends s. 39.905(1)(c), F.S., to add nonresidential outreach services to the list of minimum services that certified domestic violence centers must provide to victims. This change reflects the fact that all 41 certified domestic violence centers currently provide nonresidential outreach services as a core service. The addition of nonresidential outreach services also recognizes that not all victims require emergency shelter services, but they may require critical outreach support services to help them to safely separate from and remain separate from abusers.

The bill amends s. 39.905(6)(b), F.S., to specify that to be eligible for state funds, certified domestic violence centers must obtain public and private funding in an amount equal to at least 25 percent of the amount of funding the center receives from the Domestic Violence Trust Fund established in s. 741.01, F.S. This change will reduce the amount of match from other funding sources that certified domestic violence centers must provide to receive state funds.

[31] Section 741.325(1)(e), F.S., provides that there is an exception for local, state, or federal programs that are wholly or partly fund batterers' intervention programs.
[32] The DCF Analysis at p. 3.
[33] *Id*.
[34] *Id*. (citing Research on BIP and Policy Implications).

The bill permits certified domestic violence centers to carry forward, from one fiscal year to the next, unexpended state funds in a cumulative amount not to exceed eight percent of their total contract with the DCF. Current law allows the carrying forward of funds in the same manner for child welfare community-based care lead agencies. This change will promote a more effective use of state funds for certified domestic violence services. Funds carried forward may not be used in a way that would increase future recurring obligations, and such funds may not be used for any type of program or service that is not authorized by the existing contract. The bill requires the certified domestic violence centers to report expenditures of funds carried forward separately to the DCF, and any unexpended funds that remain at the end of the contract period must be returned to the DCF. Funds carried forward may be retained through any contract renewal so long as the same certified domestic violence center is retained by the DCF.

The bill revives, reenacts, and amends s. 741.327, F.S., to authorize the DCF to certify and monitor BIPs. The bill authorizes the DCF to adopt rules to administer this section, including but not limited to, developing criteria for the approval, suspension, or rejection of certification of BIPs. The bill removes the annual certification fee and user fee amounts from s. 741.327, F.S. It also removes the requirement that such fees assessed and collected from BIPs be deposited in the Executive Office of the Governor's Trust Fund established in s. 741.01, F.S. Finally, the bill removes the requirement for the DCF to fund the costs of certifying and monitoring BIPs.

The bill amends s. 741.325, F.S., to permit certified BIPs to use a cognitive behavioral model or a psychoeducational model in its program content. This change will give BIPs flexibility in their programs and reflects current research that BIPs that utilize a cognitive behavioral model are effective in changing behavior.

The bill amends s. 741.30, F.S., to remove language allowing the court to direct an alleged perpetrator to obtain treatment for domestic violence under s. 39.901, F.S. This deletion was necessary to conform to the changes to s. 39.901, F.S., which removes the reference to "treatment" of perpetrators of domestic violence. The court can still direct the alleged perpetrator to participate in a BIP.

The bill is effective July 1, 2021.

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:

SB 606 may have a negative fiscal impact to BIP providers if the DCF denies an application for certification. If a BIP provider is not certified, it will not be able to conduct business and provide services. Further, a BIP provider will have to go through the ch. 120, F.S., process if it chooses to challenge a denial of certification, which may result in legal costs.

The certified domestic violence centers may incur a positive fiscal impact if the bill's provision allowing the centers to carryforward funding is enacted. Certification may be easier for domestic violence centers because the amount of matching funds the center must provide may decrease.

C. Government Sector Impact:

The DCF indicates that two additional FTE positions will be required to certify and monitor BIPs statewide, as required under the bill. The department projects the cost of the positions to total $166,359 from the General Revenue Fund.[35] It is anticipated that two vacant positions and funding can be redirected from elsewhere within the agency to meet the provisions of the bill.

There is an indeterminate impact on the DCF for legal costs associated with potential administrative hearings pursuant to ch. 120, F.S., if entities denied BIP certification challenge such denial.[36]

The State Courts Administrator reports the bill would have a minimum fiscal impact on expenditures of the State Courts System.[37]

[35] The DCF Analysis at pp. 5-6.
[36] *Id.* at p. 6.
[37] Office of the State Courts Administrator, *2021 Judicial Impact Statement*, March 10, 2021 (on file with the Senate Committee on Children, Families, and Elder Affairs).

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 39.901, 39.905, 741.32, 741.325, 741.327, and 741.30 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.

The Florida Senate

Committee Agenda Request

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

Subject: Committee Agenda Request

Date: March 16, 2021

I respectfully request that **Senate Bill #606**, relating to Domestic Violence, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

04/08/2021
Meeting Date

SB 606
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 606 - Domestic Violence

Name Michael Wickersheim

Job Title Director of Legislative Affairs

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Tallahassee FL 32399
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Department of Children and Families

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

By Senator Bean

4-00322-21 2021606__

A bill to be entitled

An act relating to domestic violence; amending s. 39.901, F.S.; revising legislative findings; amending s. 39.905, F.S.; adding nonresidential outreach services to the list of services certified domestic violence centers must provide; revising requirements for receipt of state funds; authorizing certified domestic violence centers to carry forward unexpended state funds in a specified amount from one fiscal year to the next during the contract period; providing limitations on and reporting requirements for the use of such funds; requiring centers to return to the department any remaining unexpended funds at the end of the contract period; authorizing certain centers to carry forward unexpended funds through contract renewals; amending s. 741.32, F.S.; revising legislative findings; amending s. 741.325, F.S.; revising the program content requirements for batterers' intervention programs; reviving, reenacting, and amending s. 741.327, F.S., relating to the certification and monitoring of batterers' intervention programs; requiring the Department of Children and Families to certify and monitor batterers' intervention programs; requiring the department to adopt certain rules; amending s. 741.30, F.S.; conforming a provision to changes made by the act; providing an effective date.

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

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

4-00322-21 2021606__

Section 1. Section 39.901, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 39.901, F.S., for present text.)

39.901 Domestic violence centers; legislative findings; requirements.—

(1) The Legislature recognizes that the perpetration of violence by persons against their intimate partners, spouses, ex-spouses, or those with whom they share a child in common poses a significant public health threat that has adverse physical, emotional, and financial impacts on families and communities in this state. The Legislature further finds that it is critical that victims of domestic violence and their dependents have access to safe emergency shelter, advocacy, and crisis intervention services to assist them with the resources necessary to be safe and live free of violence.

(2) To ensure statewide consistency in the provision of confidential, comprehensive, and effective services to victims of domestic violence and their families, the Department of Children and Families shall certify and monitor domestic violence centers. The department and certified domestic violence centers shall serve as partners and together provide a coordinated response to address victim safety, hold batterers accountable, and prevent future violence in this state.

Section 2. Paragraph (c) of subsection (1) and paragraph (b) of subsection (6) of section 39.905, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

39.905 Domestic violence centers.—

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

(1) Domestic violence centers certified under this part must:

(c) Provide minimum services that include, but are not limited to, information and referral services, counseling and case management services, temporary emergency shelter for more than 24 hours, a 24-hour hotline, nonresidential outreach services, training for law enforcement personnel, assessment and appropriate referral of resident children, and educational services for community awareness relative to the incidence of domestic violence, the prevention of such violence, and the services available for persons engaged in or subject to domestic violence. If a 24-hour hotline, professional training, or community education is already provided by a certified domestic violence center within its designated service area, the department may exempt such certification requirements for a new center serving the same service area in order to avoid duplication of services.

(6) In order to receive state funds, a center must:

(b) Obtain public or private ~~Receive at least 25 percent of its~~ funding from one or more local, municipal, or county sources~~, public or private~~ in an amount that equals at least 25 percent of the amount of funding the center receives from the Domestic Violence Trust Fund established in s. 741.01. Contributions in kind, whether materials, commodities, transportation, office space, other types of facilities, or personal services, may be evaluated and counted as part of the required local funding.

(8) A certified domestic violence center may carry forward from one fiscal year to the next during the contract period

documented unexpended state funds in a cumulative amount that does not exceed 8 percent of its total contract with the department.

(a) The funds carried forward may not be used in a manner that would increase future recurring obligations or for any program or service that is not authorized by the existing contract.

(b) Expenditures of funds carried forward must be separately reported to the department.

(c) Any unexpended funds that remain at the end of the contract period must be returned to the department.

(d) Funds carried forward under this subsection may be retained through any contract renewals as long as the same certified domestic violence center is retained by the department.

Section 3. Section 741.32, Florida Statutes, is amended to read:

741.32 Batterers' intervention programs.—The Legislature finds that the incidence of domestic violence in this state is disturbingly high and that, despite the efforts of many to curb this violence, one person dies at the hands of a spouse, ex-spouse, or cohabitant approximately every 3 days. Further, a child who witnesses the perpetration of this violence becomes a victim as he or she hears or sees it occurring. This child is at high risk of also being the victim of physical abuse by the parent who is perpetrating the violence and, to a lesser extent, by the parent who is the victim. These children are also at a high risk of perpetrating violent crimes as juveniles and, later, becoming perpetrators of the same violence that they

witnessed as children. The Legislature finds that there should be standardized programming available to the justice system to protect victims and their children and to hold the perpetrators of domestic violence accountable for their acts. To ensure statewide consistency in such programming, the Department of Children and Families shall certify and monitor batterers' intervention programs to be used by the justice system. Finally, the Legislature recognizes that in order for batterers' intervention programs to be successful in protecting victims and their children, all participants in the justice system as well as social service agencies and local and state governments must coordinate their efforts at the community level.

Section 4. Paragraph (d) of subsection (1) of section 741.325, Florida Statutes, is amended to read:

741.325 Requirements for batterers' intervention programs.—

(1) A batterers' intervention program must meet the following requirements:

(d) The program content shall be based on a cognitive behavioral therapy model or psychoeducational model that addresses tactics of power and control by one person over another.

Section 5. Notwithstanding the repeal of section 741.327, Florida Statutes, in section 14 of chapter 2012-147, Laws of Florida, that section is revived, reenacted, and amended to read:

741.327 Certification and monitoring of batterers' intervention programs; rules ~~fees~~.—

(1) Pursuant to s. 741.32, the Department of Children and Families shall ~~Family Services is authorized to~~ certify and

monitor batterers' intervention programs ~~assess and collect:~~

~~(a) An annual certification fee not to exceed $300 for the certification and monitoring of batterers' intervention programs.~~

~~(b) An annual certification fee not to exceed $200 for the certification and monitoring of assessment personnel providing direct services to persons who:~~

~~1. Are ordered by the court to participate in a domestic violence prevention program;~~

~~2. Are adjudged to have committed an act of domestic violence as defined in s. 741.28;~~

~~3. Have an injunction entered for protection against domestic violence; or~~

~~4. Agree to attend a program as part of a diversion or pretrial intervention agreement by the offender with the state attorney~~.

(2) The department shall adopt by rule procedures to administer this section, including, but not limited to, procedures related to the development of criteria for the approval, suspension, or rejection of certification of batterers' intervention programs ~~All persons required by the court to attend domestic violence programs certified by the Department of Children and Family Services' Office for Certification and Monitoring of Batterers' Intervention Programs shall pay an additional $30 fee for each 29-week program to the Department of Children and Family Services.~~

~~(3) The fees assessed and collected under this section shall be deposited in the Executive Office of the Governor's Domestic Violence Trust Fund established in s. 741.01 and~~

~~directed to the Department of Children and Family Services to fund the cost of certifying and monitoring batterers' intervention programs~~.

Section 6. Subsection (3) of section 741.30, Florida Statutes, is amended to read:

741.30 Domestic violence; injunction; powers and duties of court and clerk; petition; notice and hearing; temporary injunction; issuance of injunction; statewide verification system; enforcement; public records exemption.—

(3)(a) The sworn petition must ~~shall~~ allege the existence of such domestic violence and must ~~shall~~ include the specific facts and circumstances upon the basis of which relief is sought.

(b) The sworn petition shall be in substantially the following form:

PETITION FOR
INJUNCTION FOR PROTECTION
AGAINST DOMESTIC VIOLENCE

Before me, the undersigned authority, personally appeared Petitioner ...(Name)..., who has been sworn and says that the following statements are true:

(a) Petitioner resides at: ...(address)...

(Petitioner may furnish address to the court in a separate confidential filing if, for safety reasons, the petitioner requires the location of the current residence to be confidential.)

(b) Respondent resides at: ...(last known address)...

(c) Respondent's last known place of employment: ...(name of business and address)...

(d) Physical description of respondent:....

Race....

Sex....

Date of birth....

Height....

Weight....

Eye color....

Hair color....

Distinguishing marks or scars....

(e) Aliases of respondent:....

(f) Respondent is the spouse or former spouse of the petitioner or is any other person related by blood or marriage to the petitioner or is any other person who is or was residing within a single dwelling unit with the petitioner, as if a family, or is a person with whom the petitioner has a child in common, regardless of whether the petitioner and respondent are or were married or residing together, as if a family.

(g) The following describes any other cause of action currently pending between the petitioner and respondent:

The petitioner should also describe any previous or pending attempts by the petitioner to obtain an injunction for protection against domestic violence in this or any other circuit, and the results of that attempt:

Case numbers should be included if available.

(h) Petitioner is either a victim of domestic violence or

has reasonable cause to believe he or she is in imminent danger of becoming a victim of domestic violence because respondent has: (mark all sections that apply and describe in the spaces below the incidents of violence or threats of violence, specifying when and where they occurred, including, but not limited to, locations such as a home, school, place of employment, or visitation exchange)

....committed or threatened to commit domestic violence defined in s. 741.28, Florida Statutes, as any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another. With the exception of persons who are parents of a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.

....previously threatened, harassed, stalked, or physically abused the petitioner.

....attempted to harm the petitioner or family members or individuals closely associated with the petitioner.

....threatened to conceal, kidnap, or harm the petitioner's child or children.

....intentionally injured or killed a family pet.

....used, or has threatened to use, against the petitioner any weapons such as guns or knives.

....physically restrained the petitioner from leaving the home or calling law enforcement.

....a criminal history involving violence or the threat of violence (if known).

....another order of protection issued against him or her previously or from another jurisdiction (if known).

....destroyed personal property, including, but not limited to, telephones or other communication equipment, clothing, or other items belonging to the petitioner.

....engaged in any other behavior or conduct that leads the petitioner to have reasonable cause to believe he or she is in imminent danger of becoming a victim of domestic violence.

(i) Petitioner alleges the following additional specific facts: (mark appropriate sections)

....A minor child or minor children reside with the petitioner whose names and ages are as follows:

....Petitioner needs the exclusive use and possession of the dwelling that the parties share.

....Petitioner is unable to obtain safe alternative housing because:

....Petitioner genuinely fears that respondent imminently will abuse, remove, or hide the minor child or children from petitioner because:

(j) Petitioner genuinely fears imminent domestic violence by respondent.

(k) Petitioner seeks an injunction: (mark appropriate section or sections)

....Immediately restraining the respondent from committing any acts of domestic violence.

....Restraining the respondent from committing any acts of domestic violence.

....Awarding to the petitioner the temporary exclusive use and possession of the dwelling that the parties share or excluding the respondent from the residence of the petitioner.

....Providing a temporary parenting plan, including a temporary time-sharing schedule, with regard to the minor child or children of the parties which might involve prohibiting or limiting time-sharing or requiring that it be supervised by a third party.

....Establishing temporary support for the minor child or children or the petitioner.

....Directing the respondent to participate in a batterers' intervention program ~~or other treatment pursuant to s. 39.901, Florida Statutes~~.

....Providing any terms the court deems necessary for the protection of a victim of domestic violence, or any minor children of the victim, including any injunctions or directives to law enforcement agencies.

(c)

Every petition for an injunction against domestic violence must ~~shall~~ contain, directly above the signature line, a statement in all capital letters and bold type not smaller than the surrounding text, as follows:

I HAVE READ EVERY STATEMENT MADE IN THIS PETITION AND EACH STATEMENT IS TRUE AND CORRECT. I UNDERSTAND THAT THE STATEMENTS MADE IN THIS PETITION ARE BEING MADE UNDER PENALTY OF PERJURY, PUNISHABLE AS PROVIDED IN

SECTION 837.02, FLORIDA STATUTES.

...(initials)...

(d) If the sworn petition seeks to determine a parenting plan and time-sharing schedule with regard to the minor child or children of the parties, the sworn petition must ~~shall~~ be accompanied by or must ~~shall~~ incorporate the allegations required by s. 61.522 of the Uniform Child Custody Jurisdiction and Enforcement Act.

Section 7. This act shall take effect July 1, 2021.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	PCS/CS/SB 700 (506336)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Rodriguez
SUBJECT:	Telehealth
DATE:	April 12, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	Gerbrandt	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 700:

- Authorizes the Agency for Health Care Administration (AHCA), subject to limitations in the General Appropriations Act, to reimburse for telehealth services involving store-and-forward technology and remote patient monitoring services under the Medicaid program.
- Expands the definition of "telehealth" in s. 456.47, F.S., to include:
  - A telehealth provider's supervision of health care services through the use of synchronous and asynchronous telecommunications technology; and
  - Telephone calls, emails, fax transmissions, and other nonpublic-facing telecommunications.
- Authorizes a telehealth provider, practicing in a manner consistent with his or her scope of practice, to prescribe Schedule III, IV, and V controlled substances through telehealth.
- Authorizes a telehealth provider, practicing in a manner consistent with his or her scope of practice, to prescribe Schedule II controlled substances under certain circumstances.
- Prohibits the prescription of Schedule I controlled substances and the issuance of physician certifications for medical marijuana through telehealth.
- Creates a new type of pharmacy establishment, a "remote-site pharmacy," that includes every location within a community mental health center or clinic in which medicinal drugs are compounded or dispensed by a registered pharmacy technician (RPT) who is remotely supervised by an off-site pharmacist acting in the capacity of prescription department manager.

- Provides for permitting and regulation of remote-site pharmacies by the Department of Health (DOH).
- Provides requirements for remote-site pharmacies.
- Authorizes a pharmacist to serve as prescription department manager for up to three remote-site pharmacies that are under common control of the same supervising pharmacy and requiring him or her to visit the remote site on a schedule as determined by the Board of Pharmacy (BOP).
- Authorizes a pharmacist, at the direction of a physician, to administer certain extended-release medications.

The bill is projected to have an insignificant negative fiscal impact on the DOH, however, the agency can absorb this impact within existing resources. See section V of this analysis.

The bill takes effect on of July 1, 2021.

II. Present Situation:

Telehealth

Terminology

Section 456.47, F.S., defines the term "telehealth" 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.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

"Store-and-forward" technology is a type of asynchronous telecommunication that allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through telecommunications technology to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service after the data has been collected.[1] The transfer of X-rays or MRI images from one health care provider to another health care provider for review in the future would be considered asynchronous telehealth through store-and-forward technology.

[1] Center for Connected Health Policy, National Telehealth Policy Resource Center, *Store-and-Forward (Asynchronous), available at* https://www.cchpca.org/about/about-telehealth/store-and-forward-asynchronous (last visited Feb. 13, 2021).

"Remote monitoring" refers to the collection, transmission, evaluation, and communication of individual health data to a health care provider from the patient's location through technology, such as wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile apps.[2] Remote monitoring can be useful for ongoing condition monitoring and chronic disease management. Depending upon the patient's needs, remote monitoring can be synchronous or asynchronous.

"Non-public facing communication technology" is a technology that, as a default, allows only the intended parties to participate in the communication. For example, Zoom, Skype, Apple FaceTime, and Facebook Messenger video chat.[3] Typically, these technologies employ end-to-end encryption, which allows only an individual and the person with whom the individual is communicating to see what is transmitted. In contrast, public-facing products such as TikTok, Facebook Live, or a public chat room are not acceptable forms of remote communication for telehealth because they are designed to be open to the public or allow wide or indiscriminate access to the communication.

Florida Telehealth Providers[4]

Currently, Florida-licensed health care providers[5] can use telehealth to deliver health care services within their respective scopes of practice.[6] An out-of-state health care provider can use telehealth to deliver health care services to Florida patients if they register with the DOH or the applicable board[7] and meet certain eligibility requirements.[8] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients, but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.[9]

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[2] American Telemedicine Association, Telehealth: Defining 21st Century Care, *available at* https://f.hubspotusercontent30.net/hubfs/5096139/Files/Resources/ATA_Telehealth_Taxonomy_9-11-20.pdf (last visited Feb. 13, 2021).

[3] U.S. Department for Health and Human Services Office for Civil Rights, FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency (Mar. 2020), *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (Feb. 14, 2021).

[4] Section 456.47(1)(b), F.S., defines the term "telehealth provider" as any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II 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).

[5] Section 456.47(1)(b), F.S.

[6] Chapter 2019-137, s. 6, Laws of Fla. In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, which created s. 456.47, F.S. (effective July 1, 2019).

[7] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH's Division of Medical Quality Assurance.

[8] Section 456.47(4), F.S.

[9] The Legislature in 2019 also passed HB 7067, which required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150, but the bill was vetoed by the Governor and did not become law. Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Feb. 14, 2021).

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below[10] and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst.
- Acupuncturist.
- Allopathic physician.
- Osteopathic physician.
- Chiropractor.
- Podiatrist.
- Optometrist.
- Nurse.
- Pharmacist.
- Dentist.
- Dental Hygienist.
- Midwife.
- Audiologist.
- Speech Therapist.
- Occupational Therapist.
- Radiology Technician.
- Electrologist.
- Orthotist.
- Pedorthist.
- Prosthetist.
- Medical Physicist.
- Emergency Medical Technician.
- Paramedic.
- Massage Therapist.
- Optician.
- Hearing Aid Specialist.
- Clinical Laboratory Personnel.
- Respiratory Therapist.
- Psychologist.
- Psychotherapist.
- Dietician/Nutritionist.
- Athletic Trainer.
- Clinical Social Worker.
- Marriage and Family Therapist.
- Mental Health Counselor.

[10] Section 456.47(1)(b), F.S. These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

In response to COVID-19, on March 16, 2020, Surgeon General Scott Rivkees executed DOH Emergency Order 20-002[11] authorizing certain out-of-state physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. This emergency order was extended[12] and will remain in effect until the expiration of the Governor's Executive Order No. 20-52 and extensions thereof.[13]

Five days later, the Surgeon General executed DOH Emergency Order 20-003[14] to also authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. This emergency order was also extended[15] and will remain in effect until the expiration of Executive Order No. 20-52 and extensions thereof.

Florida Medicaid Program

Florida Medicaid is the health care safety net for low-income Floridians. The national Medicaid program is a partnership of federal and state governments established to provide coverage for health services for eligible persons. Florida's program is administered by the Agency for Health Care Administration (AHCA) and financed through state and federal funds.[16] The AHCA is responsible for maintaining a Medicaid state plan that is approved by the Centers for Medicare and Medicaid Services (CMS). Florida Medicaid services are delivered to Medicaid recipients through either a fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a managed care plan.

Telemedicine Coverage under the Florida Medicaid Program[17]

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities, including asynchronous remote patient monitoring and store-and-forward technologies. In addition, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan

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[11] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Feb. 14, 2021).
[12] Department of Health, State of Florida, *Emergency Order DOH No. 20-011* (June 30, 2020), *available at* https://floridahealthcovid19.gov/wp-content/uploads/2020/06/DOH-Emergency-Order-DOH-No.-20-011.pdf (last visited Feb. 14, 2021).
[13] Under s. 252.36(2), F.S., no state of emergency declared pursuant to the Florida Emergency Management Act, may continue for more than 60 days unless renewed by the Governor. The state of emergency declared in Executive Order 20-52, was extended by Executive Orders 20-114, 20- 166, 20-192, 20-213, 20-276, 20-316, and 21-45. Executive Order 21-45 will remain in effect until April 28, 2021. Office of the Governor, State of Florida, *Executive Order 21-45* (Feb. 26, 2021), *available at* https://www.flgov.com/wp-content/uploads/orders/2021/EO_21-45.pdf (last visited March 17, 2021).
[14] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020), *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Feb. 14, 2021).
[15] Department of Health, State of Florida, *Emergency Order DOH No. 20-005* (Apr. 21, 2020), *available at* https://s33330.pcdn.co/wp-content/uploads/2020/04/DOH-Emergency-Order-20-005-extending-20-003.pdf (last visited Feb. 14, 2021).
[16] Section 20.42, F.S.
[17] Agency for Health Care Administration, *Senate Bill 700 Analysis* (Feb. 15, 2021) (on file with the Senate Committee on Health Policy).

must cover services via telemedicine, where appropriate, in a manner no more restrictive than the health plan would cover the service face-to-face.

Currently, Florida Medicaid reimburses for services delivered via asynchronous telemedicine in the managed care delivery system, but not in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location other than their patients and use appropriate audio-visual equipment. Florida Medicaid does not reimburse for telehealth services such as chart reviews, telephone conversations, and email or fax transmissions. In response to the COVID-19 state of emergency, the AHCA took multiple steps to expand telemedicine to prevent recipients from having lapses in treatment due to access issues. One of those changes was to allow audio-only telehealth services in both the managed care and the fee-for-service delivery systems.

Controlled Substances – Prescribing through Telehealth

Controlled Substances, Generally

Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act. This chapter classifies controlled substances into five schedules in order to regulate the manufacture, distribution, preparation, and dispensing of the substances. The scheduling of substances in Florida law is generally consistent with the federal scheduling of substances under 21 U.S.C. s. 812:

- A Schedule I substance has a high potential for abuse and no currently accepted medical use in treatment in the United States and its use under medical supervision does not meet accepted safety standards. Examples include heroin and lysergic acid diethylamide (LSD).
- A Schedule II substance has a high potential for abuse, a currently accepted but severely restricted medical use in treatment in the United States, and abuse may lead to severe psychological or physical dependence. Examples include cocaine and morphine.
- A Schedule III substance has a potential for abuse less than the substances contained in Schedules I and II, a currently accepted medical use in treatment in the United States, and abuse may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. Examples include lysergic acid, ketamine, and some anabolic steroids.
- A Schedule IV substance has a low potential for abuse relative to the substances in Schedule III, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples include alprazolam, diazepam, and phenobarbital.
- A Schedule V substance has a low potential for abuse relative to the substances in Schedule IV, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule IV. Examples include low dosage levels of codeine, certain stimulants, and certain narcotic compounds.[18]

[18] Section 893.03, F.S.

Federal Law

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008[19] amended the federal Controlled Substances Act,[20] to prohibit a practitioner from issuing a prescription for a controlled substance through the Internet without having first conducted at least one in-person medical evaluation, except in certain circumstances. After an in-person exam a prescriber may prescribe controlled substances to that patient via the Internet or a phone call. The Act offers seven exceptions to the in-person exam requirement. One such exception occurs when the Secretary of the federal Department of Health and Human Services (HHS) has declared a public health emergency.

Federal Guidance During the COVID-19 Public Health Emergency

In response to COVID-19, on January 31, 2020, the Secretary of HHS issued a public health emergency.[21] On March 16, 2020, the federal Drug Enforcement Agency (DEA) published a COVID-19 Information page on the Diversion Control Division website, authorizing qualified prescribers to issue prescriptions for all Schedule II-V controlled substances to patients without first conducting an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The evaluation is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable federal and state law.[22]

Florida Law

Section 456.44, F.S., authorizes prescribers to prescribe a three-day supply of a Schedule II opioid drugs[23] or up to a seven-day supply if medically necessary. The prescribing limits on Schedule II opioid drugs do not apply to prescriptions for acute pains related to: cancer, a terminal condition, pain treated with palliative care, or a traumatic injury with an Injury Severity Score of 9 or higher.[24]

Prescribers and dispensers are required to report to and review the Prescription Drug Monitoring Program database to review a patient's controlled substance dispensing history prior to

[19] Public Law No. 110-435 (2008).
[20] 21 U.S.C. s. 829.
[21] Determination that a Public Health Emergency Exists, Alex M. Azar II, Secretary of U.S. Department of Health and Human Services (January 31, 2020), *available at* https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx (last visited Feb. 9, 2021).
[22] Diversion Control Division, U.S. Department of Justice Drug Enforcement Administration, *COVID-19 Information Page*, *available at* https://www.deadiversion.usdoj.gov/coronavirus.html (last visited Feb. 9, 2021). Letter from Thomas Prevoznik, Deputy Assistant Administrator, Diversion Control Division, U.S. Department of Justice Drug Enforcement Administration, to DEA Qualifying Practitioners and Other Practitioners, (Mar. 31, 2020), *available at* https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf (last visited Feb. 9, 2021).
[23] All opioids are controlled substances. Opioids range in classification between Schedule I and Schedule V.
[24] Section 456.44(5)(a)2., F.S.

prescribing or dispensing a Schedule II-IV controlled substance for patients 16 years or older.[25] These prescribing limitations and requirements apply to practitioners providing services in-person and through telehealth.

Section 456.47(2)(c), F.S.,[26] prohibits telehealth providers from prescribing any controlled substance unless the controlled substance is prescribed for:

- The treatment of a psychiatric disorder;
- Inpatient treatment at a licensed hospital;
- The treatment of a patient receiving hospice services; or
- The treatment of a resident of a nursing home facility.

Florida DOH Emergency Order No. 20-002

The same day that the HHS Secretary authorized qualified prescribers to prescribe Schedule II-V controlled substances, Surgeon General Rivkees issued DOH Emergency Order No. 20-002,[27] which suspended s. 456.47(2)(c), F.S., and authorized specified Florida-licensed prescribers[28] to issue a renewal prescription for a Schedule II-IV controlled substance only for an existing patient for the purpose of treating chronic nonmalignant pain without conducting another physical examination of the patient. This emergency order was extended[29] and will remain in effect until the expiration of Executive Order No. 20-52 and extensions thereof.[30]

Physician Supervision

The Board of Medicine (BOM) defines levels of physician supervision.[31] Unless otherwise provided by law or rule, the definitions listed below will apply to all supervised licensees:

"Direct supervision" requires the physical presence of the supervising licensee on the premises so that the supervising licensee is reasonably available as needed.

"Indirect supervision" requires only that the supervising licensee practice at a location which is within close physical proximity of the practice location of the supervised licensee and that the supervising licensee must be readily available for consultation as needed. "Close physical proximity" shall be within 20 miles or 30 minutes unless otherwise authorized by the BOM.

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[25] Section 893.055, F.S.
[26] Chapter 2019-137, Laws of Fla.
[27] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020), *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Feb. 14, 2021).
[28] Physicians, osteopathic physicians, physician assistants, or advanced practice registered nurses that have designated themselves as a controlled substance prescribing practitioner on their practitioner profiles pursuant to s. 456.44, F.S.
[29] Department of Health, State of Florida, *Emergency Order DOH No. 20-011* (June 30, 2020), *available at* https://floridahealthcovid19.gov/wp-content/uploads/2020/06/DOH-Emergency-Order-DOH-No.-20-011.pdf (last visited Feb. 14, 2021).
[30] Under s. 252.36(2), F.S., no state of emergency declared pursuant to the Florida Emergency Management Act, may continue for more than 60 days unless renewed by the Governor. The state of emergency declared in Executive Order 20-52, was extended by Executive Orders 20-114, 20- 166, 20-192, 20-213, 20-276, 20-316, and 21-45. Executive Order 21-45 will remain in effect until April 28, 2021. Office of the Governor, State of Florida, *Executive Order 21-45* (Feb. 26, 2021), *available at* https://www.flgov.com/wp-content/uploads/orders/2021/EO_21-45.pdf (last visited March 17, 2021).
[31] Fla. Admin. Code R. 64B8-2.001 (2020).

"Immediate Supervision" requires the physical presence of the supervising licensee in the same room as the supervised licensee.

The Board of Osteopathic Medicine (BOOM) has no similar rule.

Advanced Practice Registered Nurses (APRNs)

In Florida, an advanced practice registered nurse (APRN), is licensed in one of five roles:
- Advanced nursing practitioner (ANP).
- Certified nurse midwife (CNM).
- Certified registered nurse anesthetist (CRNA).
- Clinical nurse specialist (CNS).
- Psychiatric nurse specialist (PNS).[32]

According to the DOH's Annual Report and Long-Range Plan 2019-2020,[33] Florida has 32,215 current and active APRNs who are regulated under the Nurse Practice Act.[34] The Board of Nursing (BON), provides by rule the criteria for an applicant to be licensed as an APRN and the applicable regulatory standards for APRN nursing practices. Additionally, the BON is responsible for administratively disciplining an APRN who commits a prohibited act.[35]

To be eligible for licensure as an APRN, an applicant must:
- Be licensed as a registered nurse;
- Have a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills; and
- Submit proof that the applicant holds a current national advanced practice certification from a BON-approved nursing specialty board.[36]

All APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility as a prerequisite to licensure/certification and biennial renewal.[37] The APRN must have professional liability coverage of at least $100,000 per claim, with a minimum annual aggregate of at least $300,000; or an unexpired irrevocable letter of credit in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the APRN as beneficiary.[38]

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[32] Section 464.003(3), F.S.
[33] Department of Health, Medical Quality Assurance, *Annual Report and Long-Range Plan 2019-2020*, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2019-2020-annual-report.pdf (last visited Feb. 11, 2020).
[34] Part I, ch. 464, F.S.
[35] Sections 464.018 and 456.072, F.S.
[36] Section 464.012(1), F.S., and Fla. Admin. Code R. 64B9-4.002 (2021).
[37] Section 456.048, F.S.
[38] Fla. Admin. Code R. 64B9-4.002 (2021). *Requirements for Licensure. See* Financial Responsibility, form number DH-MQA 1186, (Jan. 2009), incorporated by reference and *available at* http://www.flrules.org/Gateway/reference.asp?No=Ref-07539 (last visited Feb. 11, 2021).

To begin practicing as an APRN in Florida, the APRN must establish a written protocol with an osteopathic or allopathic physician, or dentist, that must be maintained on site at the location where he or she practices,[39] unless the APRN is in autonomous practice. The osteopathic or allopathic physicians, or dentist, must maintain supervision for directing the specific course of medical care and treatment the APRN provides. An APRN, within the established framework of the written protocol, may:

- Prescribe, dispense, administer, or order any drug;[40]
- Initiate appropriate therapies for certain conditions;
- Order diagnostic tests;
- Order any medication for administration to a patient in a hospital or nursing home;
- Manage selected medical problems specified in the protocol;
- Order physical and occupational therapy;
- Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses;
- Monitor and manage patients with stable chronic diseases;
- Establish behavioral problems; and
- Make medical diagnoses and treatment recommendations.[41]

An APRN who is also a certified nurse midwife[42] may, to the extent authorized by his or her established written protocol and approved by the medical staff of the health care facility he or she performs midwifery services, or the back-up physician when the delivery is performed at home, perform the following additional medical nursing functions:

- Superficial minor surgical procedures;
- Patient management during labor and delivery to include amniotomy, episiotomy, and repair;
- Ordering, initiating, and performing appropriate anesthetic procedures;
- Postpartum examination;
- Ordering appropriate medications;
- Providing family-planning services and well-woman care; and
- Managing the medical care of the normal obstetrical patient and the initial care of a newborn patient.

An APRN who is a clinical nurse specialist may perform any of the following additional medical nursing acts and functions within the framework of his or her established written protocol:

- The assessment of the health status of individuals and families using methods appropriate to the population and area of practice;
- The diagnosis of human responses to actual or potential health problems;
- Planning of health promotion, disease prevention, and therapeutic intervention in collaboration with the patient;

[39] Section 464.012(3), F.S. The DOH may, by rule, also require that a copy of the protocol be filed with the DOH along with the notice required to be filed by physicians under s. 458.348, F.S.
[40] Section 464.012(3)(a), F.S., requires that for the APRN to prescribe or dispense controlled substance as defined in s. 893.03, F.S., he or she must have graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area.
[41] Sections 464.012 and 464.003(2), F.S. In the case of multiple supervising physicians in the same group, an APRN must enter into a written supervisory protocol with at least one physician within the physician group practice.
[42] Section 467.003(2), F.S.

- Implementation of therapeutic interventions based on the nurse specialist's area of expertise and within the scope of the APRN's practice, including:
  - Direct nursing care;
  - Counseling;
  - Teaching;
  - Collaboration with other licensed health care providers;
  - Coordination of health care as necessary; and
  - Evaluation of the patient for the effectiveness of care.

An APRN psychiatric nurse,[43] within the framework of an established written protocol with a psychiatrist, may prescribe additional psychotropic controlled substances for the treatment of mental disorders.

When a physician enters into an established written protocol with an APRN, where the protocol calls for the APRN to perform general or specialized APRN medical acts and functions, the physician must submit a notice, within 30 days of entering into the protocol, to the BOM or Board of Osteopathic Medicine (BOOM), as appropriate; and must also notify the appropriate board within 30 days after the termination of the protocol. The notice must contain:

- The physician's name and license number;
- A statement that the physician has entered into a written protocol with ___ number of APRNs.[44]

There are no limits on the number of APRNs that a physician may have written protocol with or on the number of physicians an APRN may have a written protocol with.[45]

However, a physician who supervises APRNs in a medical office, other than the physician's primary practice location,[46] where the APRN is not onsite or under direct physician supervision, must comply with the following location limits:

- A physician who is engaged in "primary health care"[47] may not supervise more than four offices, in addition to his or her primary practice location.
- A physician who is engaged in "specialty health care"[48] may not supervise more than two offices, in addition to his or her primary practice location.
- A physician who is engaged in dermatologic or skin care services, including aesthetic skin care services other than plastic surgery, must:
  - Submit to the appropriate board the addresses of all locations, not his or her primary location, where he or she is supervising or has a written protocol with APRNs;

[43] Section 394.455(36), F.S.
[44] Section 459.025(1), F.S.
[45] *See* ss. 464.012, 458.348, and 459.025, F.S.
[46] Sections 458.348(3) and 459.025(3), F.S. A physician's "primary practice location" is the physician's address reflected on his or her profile published pursuant to s. 456.041, F.S.
[47] Sections 458.348(3)(a) and 459.025(3)(a), F.S., defines "primary health care" as health care services that are commonly provided to patients without referral from another practitioner, including obstetrical and gynecological services, and excludes practices providing primarily dermatologic and skin care services, which include aesthetic skin care services.
[48] Sections 458.348(3)(b) and 459.025(3)(b), F.S., defines "specialty health care" as health care services that are commonly provided to patients with a referral from another practitioner and excludes practices providing primarily dermatologic and skin care services, which include aesthetic skin care services.

- Be board certified or board eligible in dermatology or plastic surgery as recognized by the appropriate board;[49]
- Arrange for all such locations, not the physician's primary practice, to be within 25 miles of the primary practice, or in a county that is contiguous to the county of the primary practice, but in no event may any of the locations be more than 75 miles from the primary practice; and
- Supervise no more than one practice location other than his or her primary practice.[50]

Certified Registered Nurse Anesthetists (CRNAs)

An APRN who is also a CRNA may, to the extent authorized by his or her established written protocol with the supervising physician, at the facility in which he or she provides anesthetic services, perform any of the following:

- Determine patient health status as it relates to risk factors for anesthesia management.
- Determine the appropriate type of anesthesia.
- Order pre-anesthetic medication.
- Perform procedures used to render a patient insensible to pain during the performance of a surgical, obstetrical, therapeutic, or diagnostic procedure, including ordering and administering:
  - Regional anesthesia;
  - Spinal anesthesia;
  - General anesthesia;
  - Inhalation agents;
  - Intravenous agents; and
  - Hypnosis techniques.
- Monitor procedures indicated as pertinent to the anesthetic health care management of the patient.
- Provide life support functions during anesthesia, including:
  - Induction;
  - Intubation;
  - The use of appropriate mechanical supportive devices; and
  - The management of fluid, electrolyte, and blood component balances.
- Recognize and provide corrective action for abnormal patient responses to anesthesia.
- Recognize and treat cardiac arrhythmias while the patient is under anesthetic care.
- Participate in the management of the patient while in the recovery area, including ordering the administration of fluids and drugs.
- Place special peripheral and central venous and arterial lines for blood sampling and monitoring, as needed.[51]

Physician Supervision of CRNA's as a Condition of Participation in Medicare

As a condition of a hospital's participation in the Medicare program, a CRNA who administers anesthesia must be under the supervision of an operating practitioner (a physician) or an anesthesiologist (a physician specialist) who is immediately available if needed, unless the

[49] Sections 458.3312 and 459.0152, F.S.
[50] Sections 458.348(3)(c) and 459.025(3)(c), F.S.
[51] Section 464.012(4)(b), F.S.

CRNA is located in a state that has opted out of the supervision requirements.[52] Florida has not opted out.

An operating practitioner or an anesthesiologist is "immediately available" when he or she is physically located within the same area as the CRNA and is not otherwise occupied in a way that prevents an immediate hands-on intervention.[53]

As of February 1, 2021, 19 states and Guam have opted out of the federal physician supervision requirement, including Arizona, Oklahoma, Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, Wisconsin, California, Colorado, and Kentucky.[54] A state may opt out if the state's governor sends a letter to the federal Centers for Medicare & Medicaid Services requesting exemption from physician supervision of CRNAs. The governor's letter must attest that he or she has consulted with the state boards of medicine and nursing about issues relating to access to, and the quality of, anesthesia services in the state and has concluded that it is in the best interest of the state's citizens to opt-out of the federal physician supervision requirement. The opt-out must be consistent with state law.[55]

Beginning in March 2020, the federal Centers for Medicare and Medicaid began to waive the requirement that a CRNA practice under the supervision of a physician in order to allow CRNAs to function to the fullest extent allowed by states and free up physicians to expand the capacity of both CRNAs and physicians throughout the public health emergency.[56]

Physician Assistants

Physician Assistants (PAs) are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the BOM for PAs licensed under ch. 458, F.S., or the BOOM for PAs licensed under ch. 459, F.S.[57]

The Council consists of five members, appointed as follows:[58]

- The chairperson of the BOM appoints one member who is a physician and member of the BOM who supervises a PA in his or her practice;
- The chairperson of the BOOM appoints one member who is a physician and member of the BOOM who supervises a PA in his or her practice; and

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[52] 42 CFR s. 482.52.

[53] Centers for Medicare & Medicaid Services, Medicare Learning Network MLN Booklet, *Advanced practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants* (Apr. 2020), *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-For-APRNs-AAs-PAs-Text-Only.pdf (last visited Feb. 14, 2021).

[54] American Association of Nurse Anesthetists, *Certified Registered Nurse Anesthetist Fact Sheet (Feb. 1, 2021), available at* https://www.aana.com/membership/become-a-crna/crna-fact-sheet (last visited Feb. 11, 2021).

[55] 42 CFR s. 482.52(c).

[56] Centers for Medicare & Medicaid Services, Newsroom, *Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address Covid-19 Patient Surge* (Mar. 30, 2020), *available at* https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19 (last visited Feb. 12, 2012).

[57] Sections 458.347 and 459. 022, F.S.

[58] Sections 458.347(9) and 459. 022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. *See* ss. 458.307, F.S., and 459.004, F.S., respectively.

- The State Surgeon General, or his or her designee, appoints three PAs licensed under chs. 458 or 459, F.S.

The Council is responsible for:[59]

- Recommending PAs to the DOH for licensure;
- Developing rules for the boards' consideration[60] regulating the use of PAs by physicians;
- Developing rules to ensure the continuity of supervision in each practice setting;
- Making recommendations to the boards on matters relating to PAs;
- Addressing the concerns and problems of practicing PAs in order to improve safety in the clinical practices of PAs;[61]
- Denying, restricting, or placing conditions on the license of a PA who fails to meet the licensing requirements;[62] and
- Establishing a formulary of medicinal drugs that a PA may not prescribe (negative formulary).[63]

Physician Assistant Licensure

An applicant for a PA license must be at least 18 years of age. The DOH must issue a license to a person who has been certified by the Council as having met all of the following requirements:[64]

- Completed an approved PA training program.[65]
- Obtained a passing score on the National Commission on Certification of Physician Assistants exam.
- Acknowledged any prior felony convictions.
- Submitted to a background screening and have no disqualifying offenses.[66]
- Acknowledged any previous revocation or denial of licensure in any state.
- Provided a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle, a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.[67] To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially and must take a re-certification examination every 10 years.[68]

[59] Sections 458.347(9) and 459.022(9), F.S.
[60] *See* ss. 458.347(9)(c)2. and 459.022(9)(c)2., F.S.
[61] *Id.*
[62] Sections 458.347(9)(d) and 459. 022(9)(d), F.S.
[63] Section 458.347(4)(f), F.S.
[64] Sections 458.347(7) and 459.022(7), F.S.
[65] *See* Fla. Admin. Code R. 64B8-30.012 and 64B15.004 (2020).
[66] Sections 456.0135, F.S.
[67] Section 458.347(7), F.S.
[68] National Commission on Certification of Physician Assistants, *Maintaining Certification, available at* https://www.nccpa.net/certificationprocess (last visited April 5, 2021).

Physician Assistant Scope of Practice and Physician Supervision

A PA is licensed to perform only those medical services delegated to him or her by his or her supervising allopathic or osteopathic physician.[69] PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a working relationship.[70] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[71] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.[72]

Upon employment as a PA, a licensed PA must notify the DOH in writing within 30 days after such employment or after any subsequent changes of his or her supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.[73]

Supervision of a PA requires the physician to exercise responsible supervision and control and, except in cases of emergency, requires the "easy availability" or physical presence of the physician for consultation and direction of the actions of the PA. "Easy availability" is defined in current law as the ability to communicate by way of telecommunication, and the law further directs the BOM and BOOM to establish rules as to what constitutes responsible supervision of a PA.[74]

The boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate, is dependent upon all of the following factors:

- Complexity of the task.
- Risk to the patient.
- Background, training, and skill of the PA.
- Adequacy of the direction in terms of its form.
- Setting in which the tasks are performed.
- Availability of the supervising physician.
- Necessity for immediate attention.
- Number of other persons that the supervising physician must supervise.[75]

A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[76]

[69] Sections 458.347(4) and 459.022(4), F.S.
[70] Sections 458.347(2)(f) and 459.022(2)(f), F.S.
[71] Fla. Admin. Code R. 64B8-30.012 and 64B15-6.010 (2020).
[72] Sections 458.347(15) and 459.022(15), F.S.
[73] Sections 458.458.347(7) and 459.022(7), F.S.
[74] Sections 458.347(2)(f) and 459.022(2)(f), F.S.
[75] Fla. Admin. Code R. 64B8-2.001, 64B8-30.001, and 64B15-6.001 (2020).
[76] Fla. Admin. Code R. 64B8-30.012 and 64B15-6.010 (2020).

A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[77] A supervising physician may delegate the authority for a PA to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the negative formulary established by the Council[78] but only under the following circumstances:
  - The PA identifies himself or herself as a PA and advises of his or her right to see a physician before the prescription is written or dispensed;
  - The supervising physician must be registered as a dispensing practitioner[79] and have notified the DOH on an approved form of his or her intent to delegate prescriptive authority or to change prescriptive authority; and
  - The PA must have completed 10 hours of continuing medical education in the specialty practice in which the PA has prescriptive authority with each licensure renewal, and three of the 10 hours must be on the safe and effective prescribing of controlled substances.
- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under chapter 395, F.S., or a nursing homes licensed under part II of ch. 400, F.S.;[80] and
- Perform any other service that is not expressly prohibited in ch. 458, F.S., or ch. 459, F.S., or the rules adopted thereunder.[81]

Regulation of Pharmacy Establishments

Pharmacy Permitting Requirements

The Florida Pharmacy Act regulates the practice of pharmacy in Florida and contains the minimum requirements for safe practice.[82] The Board of Pharmacy (BOP) is tasked with adopting rules to implement the provisions of the act and setting the standards of practice within the state.[83] Any person who operates a pharmacy in Florida must have a permit. The DOH issues the following permits:

- Community pharmacy – A permit is required for each location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[84]

[77] *Id.*
[78] Sections 458.347(4)(f) and 459.022(e), F.S., direct the Council to establish a negative formulary listing the medical drugs that a PA may not prescribe. The negative formulary in Florida Administrative Code Rule 64B8-30.008, and 64B15-6.0038, prohibits PAs from prescribing; general, spinal or epidural anesthetics; radiographic contrast materials; and psychiatric mental health controlled substances for children younger than 18 years of age. It also restricts the prescribing of Schedule II controlled substances to a 7-day supply. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in hospitals and other facilities licensed under ch. 395, F.S.
[79] *See* s. 465.0276, F.S.
[80] Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.
[81] Sections 458.347(4) and 459.022(4), F.S.
[82] Chapter 465, F.S.
[83] Sections 465.005, 465.0155, and 465.022, F.S.
[84] Sections 465.003(11)(a)1. and 465.018, F.S.

- Institutional pharmacy – A permit is required for every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medicinal drugs are compounded, dispensed, stored, or sold.[85]
- Nuclear pharmacy – A permit is required for 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.[86]
- Special pharmacy – A permit is required for every location where medicinal drugs are compounded, dispensed, stored, or sold if the location does not otherwise meet an applicable pharmacy definition in s. 465.003, F.S.[87]
- Internet pharmacy – A permit is required for a location not otherwise licensed or issued a permit under this chapter, within or outside this state, which uses the Internet to communicate with, or obtain information from, consumers in this state to fill or refill prescriptions or to dispense, distribute, or otherwise practice pharmacy in this state.[88]
- Nonresident sterile compounding pharmacy – A permit is required for a registered nonresident pharmacy or an outsourcing facility to ship, mail, deliver, or dispense, in any manner, a compounded sterile product into this state.[89]
- Special sterile compounding – A separate permit is required for a pharmacy holding an active pharmacy permit that engages in sterile compounding.[90]

A pharmacy must pass an on-site inspection for a permit to be issued,[91] and the permit is valid only for the name and address to which it is issued.[92]

Centralized Prescription Filling

Section 465.003(16), F.S., defines the term "centralized prescription filling" as the filling (measuring the medicine and putting the right dosage into a bottle) of a prescription by one pharmacy upon request by another pharmacy to fill or refill the prescription. The term includes the performance by one pharmacy for another pharmacy of other pharmacy duties such as drug utilization review, therapeutic drug utilization review, claims adjudication, and the obtaining of refill authorizations.

Pharmacies acting as the central-fill pharmacy must have the same owner as the originating pharmacy (where the prescription is initially presented) or have a written contract specifying the services to be provided by each pharmacy, the responsibilities of each pharmacy, and the manner in which the pharmacies will comply with federal and state laws, rules, and regulations.[93]

[85] Sections 465.003(11)(a)2. and 465.019, F.S.
[86] Sections 465.003(11)(a)3. and 465.0193, F.S.
[87] Sections 465.003(11)(a)4. and 465.0196, F.S.
[88] Sections 465.003(11)(a)5. and 465.0197, F.S.
[89] Section 465.0158, F.S.
[90] Fla. Admin. Code R. 64B16-28.100 and 64B16-28.802 (2020). An outsourcing facility is considered a pharmacy and needs to hold a special sterile compounding permit if it engages in sterile compounding.
[91] Fla. Admin. Code R. 64B16-28.100 (2020).
[92] *Id.*
[93] Fla. Admin. Code R. 64B16-28.450(2) (2020).

Prescription Department Managers[94]

A prescription department manager is responsible for maintaining all drug records, providing for the security of the prescription department, and ensuring the pharmacy permittee's compliance with all statutes and rules governing the practice of the profession of pharmacy. A pharmacist may only serve as the prescription department manager of one pharmacy location. However, the BOP may grant an exception based on circumstances, such as the proximity of the pharmacy locations and the workload of the pharmacist.

All community, internet, special parenteral and enteral, special closed system, nuclear and, if applicable, special sterile compounding pharmacy permittees must continuously maintain a designated prescription department manager who is a licensed pharmacist at all times the pharmacy is open and in operation.

Regulation of Pharmacists

Pharmacist Licensure Requirements

To be licensed as a pharmacist in Florida, a person must:[95]

- 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;[96]
- 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 licensure renewal period.[97] 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 injections as a part of their renewal.[98] Pharmacists who administer long-acting antipsychotic medications must complete an approved eight-hour continuing education course as a part of the continuing education for their renewal.[99]

Pharmacist Scope of Practice

In Florida, the practice of the profession of pharmacy includes:[100]

- Compounding, dispensing, and consulting concerning the contents, therapeutic values, and uses of a medicinal drug.

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[94] See Fla. Admin. Code R. 64B16-27.450 (2020), for rules relating to prescription department managers.
[95] Section 465.007, F.S. The DOH 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.
[96] If the applicant has graduated from a four-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 BOP-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 DOH-licensed pharmacist.
[97] Section 465.009, F.S.
[98] Section 465.009(6), F.S.
[99] Section 465.1893, F.S.
[100] Section 465.003(13), F.S.

- Consultation concerning therapeutic values and interactions of patented or proprietary preparations.
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy.
- Reviewing, and making recommendations regarding the patient's drug therapy and health care status in communication with the patient's prescribing health care provider as authorized by the patient.
- Initiating, modifying, or discontinuing drug therapy for a chronic health condition under a collaborative pharmacy practice agreement.[101]
- Transmitting information from prescribers to their patients;
- Administering vaccines to adults.[102]
- Administering epinephrine injections.[103]
- Preparing prepackaged drug products in facilities holding Class III institutional facility permits.[104]
- Administering antipsychotic medications by injection.[105]
- Ordering and dispensing over-the-counter drugs approved by the FDA.[106]
- Ordering and dispensing within his or her professional judgment, subject to specified conditions:[107]
  - Certain oral analgesics for mild to moderate pain;
  - Anti-nausea preparations;
  - Certain antihistamines and decongestants;
  - Certain topical antifungal/antibacterial;
  - Topical anti-inflammatory preparations containing an amount of hydrocortisone not exceeding 2.5 percent;
  - Otic antifungal/antibacterial;
  - Salicylic acid;
  - Vitamins;
  - Ophthalmics;
  - Certain histamine H2 antagonists;
  - Acne products; and
  - Topical antivirals for herpes simplex infections of the lips.

Pharmacists are specifically prohibited from altering a prescriber's directions, diagnosing or treating any disease, initiating any drug therapy, and practicing medicine or osteopathic medicine unless permitted by law.[108]

[101] Section 465.1865, F.S.
[102] Section 465.189, F.S.
[103] *Id.*
[104] A Class III institutional pharmacy are those pharmacies affiliated with a hospital. *See* s. 465.019(2)(d), F.S.
[105] Section 465.1893, F.S.
[106] Section 465.186, F.S.
[107] Fla. Admin. Code R. 64B16-27.220 (2020).
[108] Section 465.003(13), F.S.

Only a pharmacist or registered pharmacy intern may:[109]

- Supervise or be responsible for the controlled substance inventory;
- Receive verbal prescriptions from a prescriber;
- Interpret and identify prescription contents;
- Engage in consultation with a health care practitioner regarding the interpretation of a prescription and date in a patient's profile record;
- Engage in professional communication with health care practitioners;
- Advise or consult with a patient, both as to the prescription and the patient profile record; and
- Perform certain duties related to the preparation of parenteral and bulk solutions.

Pharmacists must perform the final check of a completed prescription, thereby assuming complete responsibility for its preparation and accuracy.[110] A pharmacist must be personally available at the time of dispensing.[111] A pharmacy department is considered closed if a Florida-licensed pharmacist is not present and on duty unless the pharmacist leaves the prescription department to:[112]

- Consult, respond to inquiries, or provide assistance to customers or patients;
- Attend to personal hygiene needs; or
- Perform functions for which the pharmacist is responsible if such activities are performed in a manner that is consistent with the pharmacist's responsibility to provide pharmacy services.

Pharmacists with a Broader Scope of Practice

There are three categories of pharmacists that have broader scopes of practice than other pharmacists:

- The consultant pharmacist;[113]
- The pharmacist working under a collaborative pharmacy practice agreement with a physician to treat chronic health conditions;[114] and
- A pharmacist authorized to test or screen for and treat minor, nonchronic health conditions.[115]

Consultant Pharmacists

A consultant pharmacist works within the framework of a written collaborative practice agreement between the pharmacist and any of the following who are authorized to prescribe medicinal drugs:[116]

- A health care facility medical director;
- A medical, osteopathic, or podiatric physician; or

[109] Fla. Admin. Code R. 64B16-27.1001(1)-(2) (2020). Section 465.003(12), F.S., defines a "pharmacy intern" as a person who is currently registered in, and attending, or is a graduate of a duly accredited college or school of pharmacy and is properly registered with DOH.
[110] Fla. Admin. Code R. 64B16-27.1001(3) (2020).
[111] Fla. Admin. Code R. 64B16-27.1001(4) (2020).
[112] Section 465.003(11)(b), F.S.
[113] Sections 465.003(3) and 465.0125, F.S.
[114] Section 465.1865, F.S.
[115] Section 465.1895, F.S.
[116] Section 465.0125, F.S.

- A dentist.[117]

The consultant pharmacist may provide medication management services only at the following health care facilities:[118]

- Ambulatory surgical centers;
- Hospitals;
- Alcohol or chemical dependency treatment centers;
- Inpatient hospices;
- Nursing homes;
- Ambulatory care centers; or
- Nursing homes within a continuing care facility.

A consultant pharmacist may only provide medication management services, conduct patient assessments, and order and evaluate laboratory or clinical testing for patients of the health care practitioner with whom the consultant pharmacist has a written collaborative practice agreement.[119] The written collaborative practice agreement must outline the circumstances under which the consultant pharmacist may:

- 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. However, a consultant pharmacist may not modify or discontinue medicinal drugs prescribed by a health care practitioner who does not have a written collaborative practice agreement with the consultant pharmacist.
- Administer medicinal drugs.

A consultant pharmacist must maintain drug, patient care, and quality assurance records and, with the collaborating practitioner, must maintain written collaborative practice agreements that must be available upon request from or upon inspection by the DOH. A consultant pharmacist is not authorized to diagnose any disease or condition.[120]

Collaborative Pharmacy Practice for Chronic Health Conditions

A collaborative pharmacy practice agreement is a written agreement between a pharmacist who is certified by the BOP and a medical or osteopathic physician in which the collaborating physician authorizes a pharmacist to provide specified patient care to the physician's patients named in the agreement. A chronic health condition is defined as:

- Arthritis;
- Asthma;
- Chronic obstructive pulmonary diseases;
- Type 2 diabetes;

[117] *Id.*
[118] Section 465.1865, F.S.
[119] Section 465.0125(1), F.S.
[120] Section 465.0125(1)(c)-(d), F.S.

- Human immunodeficiency virus or acquired immune deficiency syndrome;
- Obesity; or
- Any other chronic condition adopted in rule by the BOP in consultation with the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM).[121]

The terms and conditions of the collaborative pharmacy practice agreement must be appropriate to the pharmacist's training, and the services delegated to the pharmacist must be within the collaborating physician's scope of practice. A collaborative pharmacy practice agreement must include the following:

- The name(s) of the collaborating physician's patient or patients for whom a pharmacist may provide services;
- Each chronic health condition to be collaboratively managed;
- Specific medicinal drug or drugs to be managed by the pharmacist for each patient;
- Circumstances under which the pharmacist may order or perform and evaluate laboratory or clinical tests;
- Conditions and events upon which the pharmacist must notify the collaborating physician and the manner and timeframe in which such notification must occur;
- Beginning and ending dates for the collaborative pharmacy practice agreement and termination procedures, including procedures for patient notification and medical records transfers; and
- A statement that the collaborative pharmacy practice agreement may be terminated, in writing, by either party at any time.[122]

A pharmacist may not modify or discontinue medicinal drugs prescribed by a health care practitioner with whom he or she does not have a collaborative pharmacy practice agreement. A physician may not delegate the authority to initiate or prescribe a controlled substance to a pharmacist.[123]

Testing or Screening for and Treatment of Minor, Nonchronic Health Conditions

The scope of practice for a pharmacist, within the framework of an established written protocol with a supervising medical or osteopathic physician, may also include the testing or screening for and treatment of minor, nonchronic health conditions, which are defined as short-term conditions that are generally managed with minimal treatment or self-care, and include:

- Influenza;
- Streptococcus;
- Lice;
- Skin conditions such as ring worm and athletes foot; and
- Minor, uncomplicated infections.[124]

The written protocol between a supervising physician and a pharmacist who has been certified by the BOP to provide the services listed above must include particular terms and conditions

[121] Section 465.1865(1)(a)-(b), F.S.
[122] Section 465.1865(3)(a), F.S.
[123] Section 465.1865(4)-(5), F.S.
[124] Section 465.1895(1), F.S.

imposed by the supervising physician. The terms and conditions must be appropriate to the pharmacist's training. A pharmacist who enters into such a protocol with a supervising physician must submit the protocol to the BOP. At a minimum, the protocol must include:

- Specific categories of patients who the pharmacist is authorized to test or screen for and treat minor, nonchronic health conditions.
- The physician's instructions for obtaining relevant patient medical history for the purpose of identifying disqualifying health conditions, adverse reactions, and contraindications to the approved course of treatment.
- The physician's instructions for the treatment of minor, nonchronic health conditions based on the patient's age, symptoms, and test results, including negative results.
- A process and schedule for the physician to review the pharmacist's actions under the protocol.
- A process and schedule for the pharmacist to notify the physician of the patient's condition, tests administered, test results, and course of treatment.
- Any other requirements as established by the BOP in consultation with the BOM and the BOOM.[125]

A pharmacist authorized to test and screen for and treat minor, nonchronic conditions under a protocol must provide evidence of current certification by the BOP to his or her supervising physician. A supervising physician must review the pharmacist's actions in accordance with the protocol.[126]

Pharmacist Supervision of Registered Pharmacy Interns

A person seeking licensure as a pharmacist must submit proof that he or she has completed an internship program.[127] To become a registered pharmacy intern, a person must be certified by the BOP and enrolled in an intern program at an accredited school or college of pharmacy or as a graduate of an accredited school or college of pharmacy and not yet licensed as a pharmacist in Florida.[128]

A pharmacist is responsible for any delegated act performed by a registered pharmacy intern employed or supervised by the pharmacist.[129] A registered intern may fill, compound, or dispense prescriptions or medicinal drugs only under the "direct and immediate personal supervision" of a licensed pharmacist.[130]

[125] Section 465.1895(5)(a), F.S.
[126] Section 465.1895(5)(b), F.S.
[127] Section 465.007(1)(c), F.S.
[128] Section 465.013, F.S. *See also* Fla. Admin. Code R. 64B16-26.2032 (2020) (U.S. pharmacy students/graduates); Fla. Admin. Code R. 64B16-26.2033 (2020) (foreign pharmacy graduates).
[129] Fla. Admin. Code R. 64B16-27.430 (2020).
[130] Section 465.015(1)(b) and (2)(b), F.S.

Regulation of Pharmacy Technicians

Pharmacy Technician Registration Requirements

Pharmacy technicians assist pharmacists in dispensing medications and are accountable to a supervising pharmacist who is legally responsible for the care and safety of the patients served.[131] A person must register with the DOH to practice as a pharmacy technician. To register, an individual must:[132]

- Be at least 17 years of age;
- Submit an application and pay an application fee; and
- Complete a BOP-approved pharmacy technician training program.[133]

The pharmacy technician must renew the registration biennially. For each renewal cycle, a pharmacy technician must complete 20 continuing education hours.[134]

Pharmacy Technician Training Programs

The BOP has preapproved certain training programs that have been accredited by certain accreditation agencies or provided by a branch of the United States Armed Forces.[135] The BOP may review and approve other training programs that do not meet the criteria for pre-approval. Such programs must be licensed by the Commission for Independent Education or equivalent licensing authority or be within the public school system of this state and offer a course of study that includes:

- Introduction to pharmacy and health care systems;
- Confidentiality;
- Patient rights and the federal Health Insurance Portability and Accountability Act (HIPAA);
- Relevant state and federal law;
- Pharmaceutical topics, including medical terminology, abbreviations, and symbols; medication safety and error prevention; and prescriptions and medication orders;
- Records management and inventory control, including pharmaceutical supplies, medication labeling, medication packaging and storage, controlled substances, and adjudication and billing;
- Interpersonal relations and ethics, including diversity of communications, empathetic communications, ethics governing pharmacy practice, patient and caregiver communications; and
- Pharmaceutical calculations. [136]

[131] Section 465.014(1), F.S.
[132] Section 465.014(2), F.S.
[133] An individual is exempt from the training program if he or she was registered as a pharmacy technician before January 1, 2011, and either worked as a pharmacy technician at least 1,500 hours under a licensed pharmacists or received certification from an accredited pharmacy technician program.
[134] Section 465.014(6), F.S.
[135] Fla. Admin. Code R. 64B16-26.351(1)-(2) (2020).
[136] Fla. Admin. Code R. 64B16-26.351(3)(b) (2020).

The training program must provide the BOP with educational and professional background of its faculty.[137] A licensed pharmacist or registered pharmacy technician with appropriate expertise must be involved with planning and instruction and must supervise learning experiences.[138]

The BOP may also review and approve employer-based pharmacy technician training programs. An employer-based program must be offered by a Florida-permitted pharmacy or affiliated group of pharmacies under common ownership.[139] The program must include 160 hours of training over a period of no more than six months and may be provided only to the employees of that pharmacy.[140] The employer-based training program must:

- Meet the same qualifications as required for non-employment based pharmacy technician training programs as indicated above;
- Provide an opportunity for students to evaluate learning experiences, instructional methods, facilitates, and resources;
- Ensure that self-directed learning experiences, such as home study or web-based courses, evaluate the participant's knowledge at the completion of the learning experience; and
- Designate a person to assume responsibility for the registered pharmacy technician-training program.[141]

Pharmacy Technician Scope of Practice

A registered pharmacy technician may not engage in the practice of the profession of pharmacy; however, a licensed pharmacist may delegate those duties, tasks, and functions that do not fall within the definition of the practice of professional pharmacy.[142] The BOP specifies, by rule, certain acts that registered pharmacy technicians are prohibited from performing, which include:

- Receiving new verbal prescriptions or any change in the medication, strength, or directions of an existing prescription;
- Interpreting a prescription or medication order for therapeutic acceptability and appropriateness;
- Conducting a final verification of dosage and directions;
- Engaging in prospective drug review;
- Monitoring prescription drug usage;
- Transferring a prescription;
- Overriding clinical alerts without first notifying the pharmacist;
- Preparing a copy of a prescription or reading a prescription to any person for the purpose of providing reference concerning treatment of the patient for whom the prescription was written;
- Engaging in patient counseling; or
- Engaging in any other act that requires the exercise of a pharmacist's professional judgment.[143]

[137] Fla. Admin. Code R. 64B16-26.351(3)(e) (2020).
[138] *Id.*
[139] Fla. Admin. Code R. 64B16-26.351(4) (2020).
[140] *Id.*
[141] *Id.*
[142] Section 465.014(1), F.S.
[143] Fla. Admin. Code R. 64B16-27.420(2) (2020).

A registered pharmacy technician must wear an identification badge with a designation as a "registered pharmacy technician" and identify herself or himself as a registered pharmacy technician in telephone or other forms of communication.[144]

Pharmacist Supervision of Pharmacy Technicians

A licensed pharmacist must directly supervise the performance of a registered pharmacy technician[145] and is responsible for acts performed by persons under his or her supervision.[146] A pharmacist may use technological means to communicate with or observe a registered pharmacy technician who is performing delegated tasks.[147]

Florida law prohibits a pharmacist from supervising more than one registered pharmacy technician, unless otherwise permitted by guidelines adopted by the BOP.[148] The guidelines include the following restrictions:[149]

- A pharmacist engaging in sterile compounding may supervise up to three registered pharmacy technicians.
- A pharmacist who is not engaged in sterile compounding may supervise up to six registered pharmacy technicians.
- In a pharmacy that does not dispense medicinal drugs, a pharmacist may supervise up to eight registered pharmacy technicians, as long as the pharmacist or pharmacy is not involved in sterile compounding.
- In a pharmacy that dispenses medicinal drugs in a physically separate area[150] of the pharmacy from which medicinal drugs are not dispensed, a pharmacist may supervise up to eight registered pharmacy technicians.

The Federal Health Insurance Portability and Accountability Act (HIPAA)[151]

HIPAA Privacy Rule[152]

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. The HIPAA Privacy Rule sets national standards for when protected health information (PHI) may be used and disclosed.

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[144] Fla. Admin. Code R. 64B16-27.100(2) (2020).
[145] Direct supervision means supervision by a pharmacist who is on the premises at all times the delegated tasks are being performed; who is aware of delegated tasks being performed; and who is readily available to provide personal assistance, direction, and approval throughout the time the delegated tasks are being performed (Fla. Admin. Code R. 64B16-27.4001(2)(a)).
[146] Fla. Admin. Code R. 64B16-27.1001(7) (2020).
[147] Fla. Admin. Code R. 64B16-27.4001(2)(b) (2020).
[148] Section 465.014(1), F.S.
[149] Fla. Admin. Code R. 64B16-27.410 (2020).
[150] A "physically separate area" is a part of the pharmacy that is separated by a permanent wall or other barrier, which restricts access between the two areas.
[151] Centers for Medicare & Medicaid Services, Medicare Learning Network Fact Sheet, HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules (Sept. 2018), *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurityTextOnly.pdf (last visited Feb. 14, 2021).
[152] 45 C.F.R. Part 160 and Subparts A and E of Part 164.

Only certain entities and their business associates are subject to HIPAA's provisions. These covered entities include: health plans, health care providers; and health care clearinghouses.

The Privacy Rule gives individuals privacy and confidentiality rights with respect to their PHI, including rights to examine and obtain a copy of their health records in the form and manner they request, and to ask for corrections to their information. Also, the Privacy Rule permits the use and disclosure of health information needed for patient care and other important purposes.

The Privacy Rule protects PHI held or transmitted by a covered entity or its business associate, in any form, whether electronic, paper, or verbal. PHI includes information that relates to any of the following:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual.

HIPAA Security Rule[153]

The HIPAA Security Rule specifies safeguards that covered entities and their business associates must implement to protect electronic PHI (ePHI) confidentiality, integrity, and availability.

Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit. Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation. What is reasonable and appropriate depends on the nature of the entity's business as well as its size, complexity, and resources.

Under the Security Rule, covered entities must:

- Ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

When developing and implementing Security Rule compliant safeguards, covered entities and their business associates may consider all of the following:

- Size, complexity, and capabilities.
- Technical, hardware, and software infrastructure.
- The costs of security measures.
- The likelihood and possible impact of risks to ePHI.

Covered entities must review and modify security measures to continue protecting ePHI in a changing environment.

[153] 45 C.F.R. Part 160 and Subparts A and C of Part 164.

HIPAA Breach Notification Rule[154]

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals; the federal HHS; and, in some cases, the media of a breach of unsecured PHI. Generally, a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

The impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates a low probability that the PHI has been compromised based on a risk assessment of, at a minimum, the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Most notifications must be provided without unreasonable delay and no later than 60 days following the breach discovery. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Notification of Enforcement Discretion during Public Health Emergency

Covered health care providers acting in good faith will not be subject to penalties for violations of the HIPAA Privacy Rule, the HIPAA Security Rule, or the HIPAA Breach Notification Rule that occur in the good faith provision of telehealth during the public health emergency.[155]

On March 17, 2020, the federal Department of Health & Human Services (HHS) Office for Civil Rights (OCR) issued a Notification of Enforcement of Discretion, meaning that the OCR may exercise its enforcement discretion and not pursue penalties for HIPPA violations against health care providers that serve patients through everyday communication technologies during the public health emergency.[156] If a provider follows the terms of the Notification and any applicable OCR guidance, it will not face HIPAA penalties if it experiences a hack that exposes PHI from a telehealth session.[157]

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[154] 45 C.F.R. Subpart D.
[155] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (Feb. 14, 2021).
[156] Press Release, U.S. Department of Health and Human Services, *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Mar. 17, 2021) *available at* https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html (last visited Feb. 14, 2021).
[157] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (Feb. 14, 2021).

Jurisdiction and Venue for Telehealth-related Actions[158]

For purposes of s. 456.47, F.S., any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the DOH, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider may be located in the patient's county of residence or in Leon County.

III. Effect of Proposed Changes:

Section 1 amends s. 409.908, F.S., to require the AHCA to reimburse Medicaid providers for the use of telehealth, including services provided in real time, store-and-forward technologies, and remote patient monitoring services, subject to any limitations or directions provided in the General Appropriations Act. Currently, Medicaid health plans have broad flexibility in covering telemedicine services, including remote patient monitoring and store-and-forward services. Throughout the duration of the public health emergency, the AHCA has expanded services under the fee-for-service delivery system to cover store-and-forward and remote patient monitoring modalities rendered by licensed physicians, APRNs, and PAs functioning within their scope of practice.

The bill requires providers to ensure that such services are medically necessary and performed within a provider's scope of practice and within applicable supervision requirements. The bill requires providers to document the use of telehealth in the patient's medical record or progress notes. The AHCA already requires this of providers.

The bill authorizes out-of-state providers who are registered under s. 456.47(4), F.S., and enrolled in Florida Medicaid as an out-of-state provider to be reimbursed for telehealth services provided to recipients in this state.

The reimbursements required and authorized in Section 1 do not cover the purchase of telecommunications equipment used for the provision of telehealth, such as computers, tablets, or smartphones.

Section 1 requires the AHCA to reimburse pharmacists for healthcare services that are provided through telehealth.

Section 2 amends s. 456.47, F.S., to expand the definition of "telehealth" to include:

- A telehealth provider's supervision of the provision of health care services through the use of synchronous and asynchronous telecommunications technology.
- Telephone calls, emails, fax transmissions, and other nonpublic-facing telecommunications. Under current law, audio-only telephone calls, email messages, and fax transmissions are explicitly excluded from the definition of telehealth.

Section 2 authorizes a telehealth provider, acting within the scope of his or her practice, to prescribe controlled substances listed in Schedule III, Schedule IV, and Schedule V of s. 893.03,

[158] Section 456.47(5), F.S.

F.S. The bill also authorizes a telehealth provider to prescribe Schedule II controlled substances if prescribed for any of the following:

- The treatment of a psychiatric disorder.
- Inpatient treatment at a hospital licensed under ch. 395, F.S.
- The treatment of a patient receiving hospice services.
- The treatment of a resident of a nursing home facility.

The telehealth provider must also comply with ch. 893, F.S., by consulting and reporting to the Prescription Drug Monitoring Program database. This change removes the prohibition on prescribing controlled substances via telehealth.[159]

The bill prohibits telehealth providers from using telehealth to prescribe Schedule I controlled substances or issuing a physician certification for the medical use of marijuana.

The bill amends an exemption from telehealth registration requirements for out-of-state telehealth providers who provide services in consultation with a healthcare professional licensed in Florida who has authority over the diagnosis and care of the patient. Current law requires that the out-of-state telehealth provider consult with a Florida licensed healthcare provider who has "ultimate" authority over the diagnosis and care of the patient.

Sections 3 and 4 amend ss. 458.347 and 459.022, F.S., the practice acts for allopathic and osteopathic PAs, respectively, to revise the definitions of the terms "supervision" and "easy availability." In both sections, the bill replaces "telecommunication" with "telehealth" as defined in s. 456.47(1), F.S.," to allow for the remote physician supervision of PAs via telehealth.

Section 5 amends s. 465.003, F.S., to create a new type of pharmacy establishment. This section expands the definition of "pharmacy" to include "remote-site pharmacies." The term "remote-site pharmacy" or "remote site" is defined as every location within a community mental health center or clinic as defined in s. 394.455, F.S., where medicinal drugs are compounded or dispensed by a registered pharmacy technician who is remotely supervised by an off-site pharmacist acting in the capacity of a prescription department manager.
Section 6 creates s. 465.0198, F.S., and establishes the permitting of and regulation of remote-site pharmacies.

The term "supervising pharmacy" is defined as a pharmacy licensed in this state which employs a licensed pharmacist who remotely supervises a registered pharmacy technician at a remote-site pharmacy.

The bill requires a person desiring a permit to operate a remote-site pharmacy to apply to the DOH. If the Board of Pharmacy (BOP) certifies that the application complies with the laws and rules of the BOP,[160] the DOH must issue the permit. To obtain a permit, a licensed pharmacist or a consultant pharmacist must be designated as the prescription department manager responsible for the oversight of the remote site. The permittee must notify the DOH within 10 days after any change of the prescription department manager.

[159] Section 456.47(2)(c), F.S.
[160] The BOP has rulemaking authority under s. 465.005, F.S., to implement the provisions of ch. 465.

Under the bill, a remote-site pharmacy must:

- Be jointly owned or operated under contract with a supervising pharmacy.
- Maintain a video surveillance system that records continuously 24 hours per day and retain video surveillance recordings for at least 45 days.
- Display a sign visible to the public indicating that the location is a remote-site pharmacy and that the facility is under 24-hour video surveillance.
- Maintain a policies and procedures manual, which must be made available to the BOP or its agent upon request. The manual must contain, at a minimum, all of the following:
  - A description of how the pharmacy will comply with federal and state laws and rules.
  - The procedures for supervising the remote site and counseling its patients.
  - The procedures for reviewing the prescription drug inventory and drug records maintained by the remote site.
  - The policies and procedures for providing security adequate to protect the confidentiality and integrity of patient information.
  - The written plan for recovery from an event that interrupts or prevents the prescription department manager from supervising the remote site's operation.
  - The procedures for use of the state prescription drug monitoring program by the prescription department manager before he or she may authorize the dispensing of any controlled substance.
  - The procedures for maintaining a perpetual inventory of the controlled substances listed in s. 893.03(2), F.S.
  - The specific duties, tasks, and functions that registered pharmacy technicians are authorized to perform at the remote site.

The bill specifies that a remote-site pharmacy is not considered a pharmacy location for purposes of network access in managed care programs. The bill authorizes a remote-site pharmacy to store, hold, or dispense any medicinal drug, but prohibits centralized prescription filling. The bill requires a prescription department manager to visit the remote site, based on a schedule adopted by the BOP, to inspect the pharmacy, address personnel matters, and provide clinical services for patients.

A registered pharmacist may serve as the prescription department manager for up to three remote-site pharmacies that are under common control of the same supervising pharmacy.

Section 7 amends s. 465.1893, F.S., to authorize a pharmacist who is authorized under current law to administer long-acting antipsychotic medication by injection, to also administer by injection an extended-release medication indicated to treat opioid use disorder, alcohol use disorder, or other substance use disorders or dependency, including but not limited to, buprenorphine, naltrexone, or other medications that have been approved by the United States Food and Drug Administration. The bill requires a pharmacist seeking to administer such medications to fulfill the eight-hour continuing education course requirement that applies to pharmacists seeking to administer long-acting antipsychotic medication. Under the bill, that course must also cover addiction medications.

Section 8 provides an effective date of July 1, 2021.

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:

Section 19, Article VII of the State Constitution requires a state tax or fee that is imposed or authorized by the Legislature to be "contained in a separate bill that contains no other subject." The provisions of section 5 amending s. 465.033(11)(a), F.S., and of section 6 creating s. 465.0198, F.S., could result in the authorization of or imposition of the existing fees in s. 465.022(3),(7), and (14), F.S., on a new class of persons seeking a permit for a remote-site pharmacy. An amendment to this bill or a separate fee bill should be considered to address the applicable fees.

E. Other Constitutional Issues:

Section 6, Article III of the State Constitution requires every law to "embrace but one subject and matter properly connected therewith, and the subject shall be briefly expressed in the title." The subject as expressed in the title circumscribes the one subject to which the act must relate. CS/SB 700 is titled "An act relating to telehealth," but the following section of the bill does not, or does not necessarily, relate to telehealth:

- Section 7 of the bill amends s. 465.1893, F.S., to authorize pharmacists to administer specified medications by injection, which can be done only in-person, not by telehealth.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill has an indeterminate fiscal impact on the private sector.

C. Government Sector Impact:

PCS/CS/SB 700 creates a new type of pharmacy establishment, a "remote-site pharmacy," and requires the DOH to permit and regulate them. The agency may have an

insignificant negative fiscal impact due to the bill's creation of remote-site pharmacies, however, the agency can absorb the costs associated with regulation and permitting of the new establishments.

The AHCA does not expect this bill to have a fiscal impact on Medicaid. The bill is unlikely to increase the overall costs to the Medicaid program, as the majority of Medicaid recipients are already covered for the newly-required covered services under Medicaid health plans. Changes in the bill will pose operational impacts to the AHCA, including updating rules, amending the state plan, enrolling new providers, and programming the claims payment and enrollment systems. These actions are part of the AHCA's routine business practices and do not require an appropriation.[161]

VI. Technical Deficiencies:

Section 7 of the bill amends s. 465.1893, F.S., to authorize in-person pharmacists to administer specified medications. Lines 301-305 of the bill could be interpreted to authorize a pharmacist to administer a long-acting antipsychotic medication that has not been approved by the United States Food and Drug Administration. Such approval is required under current law. If this is not the intent, then those lines should be amended to provide clarification.

VII. Related Issues:

The bill specifies that a remote-site pharmacy is a place in which medicinal drugs are compounded or dispensed by a registered pharmacy technician who is remotely supervised by an off-site pharmacists acting in the capacity of a prescription department manager. However, it is unlawful for a registered pharmacy technician to compound and dispense medicinal drug under the remote supervision of an off-site pharmacist due to the following provisions in current law:

- Under s. 465.014(1), F.S. a registered pharmacy technician is specifically prohibited from engaging in the practice of pharmacy, which includes the compounding and dispensing of medicinal drugs.
- Under s. 465.015, F.S., it is a misdemeanor of the first degree for any person to own or operate a pharmacy in which a person, not licensed as a pharmacist or registered as an intern, compounds or dispenses medicinal drugs.
- Under s. 465.015, F.S., it is a felony of the third degree for anyone other than a licensed pharmacist or registered intern to dispense medicinal drugs.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.908, 456.47, 458.347, 459.022, 465.003, and 468.1893.

This bill creates section 465.0198 of the Florida Statutes.

[161] Agency for Health Care Administration, *Senate Bill 700 Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy.)

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 April 8, 2021:
The CS

- Deletes from the underlying bill provisions related audiologists and hearing aid specialists.
- Deletes from the underlying bill the authority for non-healthcare practitioners who are required to maintain a formal supervisory relationship to satisfy such relationship through telehealth.
- Allows for Medicaid to reimburse pharmacists for services provided through telehealth.
- Allows telehealth providers to prescribe Schedule II controlled substances if prescribed for the following:
  - Treatment of psychiatric disorders.
  - Hospital inpatient treatment.
  - Treatment of patients receiving hospice services.
  - Treatment of residents of a nursing facility.
- Prohibits telehealth providers from prescribing Schedule I controlled substances or issuing a physician certification for marijuana for medical use.
- Amends an exemption from telehealth registration requirements for out-of-state telehealth providers who provide services in consultation with a healthcare professional licensed in Florida who has authority over the diagnosis and care of the patient. Current law requires that the out-of-state telehealth provider consult with a Florida licensed healthcare provider who has "ultimate" authority over the diagnosis and care of the patient.
- Creates a new type of pharmacy establishment, a "remote-site pharmacy," that includes every location within a community mental health center or clinic where medicinal drugs are compounded or dispensed by a registered pharmacy technician (RPT) who is remotely supervised by an off-site pharmacist acting in the capacity of prescription department manager.
- Deletes from the underlying bill a provision that prohibits a remote-site pharmacy from performing centralized prescription filling.
- Deletes from the underlying bill provisions making it lawful for a registered pharmacy technician to compound and dispense medicinal drugs under the supervision of an off-site pharmacist.
- Deletes from the underlying bill requirements of remote-site pharmacies.

CS by Health Policy on February 17, 2021:
The CS:

- Deletes lines 164-166 from the underlying bill to remove a provision that would have prohibited physicians registered as out-of-state providers from remotely supervising nonphysician health care practitioners in the provision of a service that requires direct supervision under the laws and rules in this state.

- Deletes lines 159-164 from the underlying bill to remove duplicative language already authorized by lines 127 and 148-153.
- Adds provisions relating to pharmacist-administered medications. The CS amends s. 456.1893, F.S., to authorize a pharmacist, at the direction of a physician, to administer by injection an extended-release medication indicated to treat opioid use disorder, alcohol use disorder, or other substance use disorder or dependency, including but not limited to, buprenorphine, naltrexone, or other medications that have been approved by the United States Food and Drug Administration. The CS requires a pharmacist seeking to administer such medications to complete an eight-hour continuing education course that must, under the CS, include education on addiction.
- Adds provisions relating to hearing aids:
  - The CS amends ss. 468.1225 and 484.0501, F.S., respectively, to create exceptions for audiologists and hearing aid specialists from procedural and equipment requirements when they are fitting and selling hearing aids to persons who are 18 years of age or older and who provide a medical clearance or a waiver. The amendments to s. 484.0501, F.S., change the requirement that a hearing aid specialist make a final fitting, to ensure the physical and operational comfort of the hearing aid, so that it applies to clients younger than 18 years of age in all cases. Under the CS, a final fitting by a hearing aid specialist is only required "when indicated" for clients 18 years of age or older.
  - The CS amends ss. 468.1265 and 484.054, F.S., respectively, to make it lawful for a person to sell or distribute hearing aids through the mail to an ultimate consumer who is 18 years of age or older. Under current law, selling or distributing hearing aids through the mail to the ultimate consumer of any age constitutes a second degree misdemeanor.

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: February 17, 2021

I respectfully request that **Senate Bill #700**, relating to Telehealth, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 39

File signed original with committee office

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

4/8/2021
Meeting Date

CS SB 700
Bill Number (if applicable)

Amnt 520292 to Amnt 645592
Amendment Barcode (if applicable)

Topic Telehealth

Name Joy M. Ryan

Job Title Lobbyist

Address PO Box 11247
Street

Phone 850.425.4000

Tallahassee FL 32302
City *State* *Zip*

Email joy@meenanlawfirm.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Teladoc Inc.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

4/8/2021
Meeting Date

700
Bill Number (if applicable)

607286
Amendment Barcode (if applicable)

Topic Telehealth

Name Jake Farmer

Job Title Director of Government Affairs

Address 227 S Aams Street
Street

Phone 352-359-6835

Tallahassee FL 32301
City *State* *Zip*

Email jake@frf.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Retail Federation

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 700
Bill Number (if applicable)

G 15592 (Delete All)
Amendment Barcode (if applicable)

Topic SB 700 (delete all amendment)

Name Claudia Davant

Job Title lobbyist

Address 205 S adams St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-567-0979

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

April 8 2021
Meeting Date

SB700
Bill Number (if applicable)

645592
Amendment Barcode (if applicable)

Topic Remote site pharmacy

Name Michael Jackson

Job Title Executive Vice President & CEO

Address 610 North Adams Street
Street

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

Phone (850) 222-2400

Email jackson@pharmview.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/18/21
Meeting Date

700
Bill Number (if applicable)

☆ SE amdmt
Amendment Barcode (if applicable)

645592

Topic Telehealth

Name Ron Watson

Job Title Lobbyist

Address 9114 Seafair Lane
Street
Tallahassee FL 32317
City *State* *Zip*

Phone 86 567-1202

Email watson.ron@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing MiV Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

700
Bill Number (if applicable)

Topic Telehealth for MMJ

Amendment Barcode (if applicable)

Name Jodi James

Job Title Legislative Chair

Address 1375 Cypress Ave
Street
Melbourne FL 32935
City *State* *Zip*

Phone 321 890 7302

Email jodi@FLCAN.org

Speaking: ☐ For ☒ Against ☐ Information
MMJ inclusion

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

Representing Florida Cannabis Action Network

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 700
Bill Number (if applicable)

172640
Amendment Barcode (if applicable)

Topic Audiology Deletion

Name Robert Fifer, PHD

Job Title Audiologist

Address 11273 SW 153 Avenue
Street

Phone

Miami FL 33196
City *State* *Zip*

Email Rfifer@med.Miami.EDU

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

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

Representing FLASHA

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

8 April 2021 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 700

Meeting Date *Bill Number (if applicable)*

Topic Telehealth *Amendment Barcode (if applicable)*

Name Diego Echeverri

Job Title Legislative Liaison

Address _____ Phone _____

Street

_____ Email _____

City *State* *Zip*

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

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

Representing Americans For Prosperity

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

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

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

4/8/2021
Meeting Date

700
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Telehealth

Name Jake Farmer

Job Title Director of Government Affairs

Address 227 S Adams Street
Street

Phone 352-359-6835

Tallahassee FL 32301
City *State* *Zip*

Email jake@frf.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Retail Federation

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 700
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Theresa Bulger (pronounced BULL-jer)

Job Title Lobbyist

Address 1700 N. Monroe St Suite #11 Phone 850 792 HEAR
Street

Box #182 Tallahassee, FL 32303 Email tb@deafkids can. org
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

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

Representing AGBell Association of DEAF, FL Coalition of Clarke School Certified Speech and Hearing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

700
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Chris Nland

Job Title _____

Address 4427 Herschel St
Street
Jacksonville FL 32210
City *State* *Zip*

Phone 904-233-3051

Email nlandlaw@aol.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

700
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Steve Winn

Job Title Exec. Director

Address 2544 Blairstone Pines Dr
Street

Phone 878-7364

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Osteopathic Medical Assoc.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

4/8/21
Meeting Date

SB700
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Telehealth

Name Shane Messer

Job Title Government Affairs Director

Address 316 E Park Ave
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-224-6048

Email shane@floridabha.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Council for Behavioral Healthcare

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 700
Bill Number (if applicable)

172640
Amendment Barcode (if applicable)

Topic Amendment on Audiology

Name Janet Deig

Job Title Secretary

Address 1010 Granville Rd.
Street

Jacksonville, FL 32205
City *State* *Zip*

Phone 904 614 6052

Email Jane.deig@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing SELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 700
Bill Number (if applicable)

172640
Amendment Barcode (if applicable)

Topic Strike Amendment

Name Elizibeth Deig

Job Title

Address 6269 Woodhaven Village Dr. Phone NA
Street

Port Orange FL 32128 Email NA
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 700
Bill Number (if applicable)

17 2640
Amendment Barcode (if applicable)

Topic Deletion 417-312

Name Danny Deig

Job Title student

Address 6269 Woodhaven Village Dr.
Street

Port Orange FL 32128
City *State* *Zip*

Phone 904 536 6059

Email N/A

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Children who are Deaf

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

SB 709
Bill Number (if applicable)

172640
Amendment Barcode (if applicable)

Topic Deleting 417 - 512

Name Alexandria Marie Deig

Job Title Professor/Teacher

Address 6269 Woodhaven Village Dr. Phone 904 536 6059
Street

Port Orange FL 32128 Email Deigfamily103010@gmail.com
City *State* *Zip*

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

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

Representing Parents of children who are Deaf

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

Bill Number (if applicable)

045592
Amendment Barcode (if applicable)

Topic Telehealth

Name Jodi James

Job Title Legislative Chair

Address 1375 Cypress Ave
Street

Melbourne FL 32935
City *State* *Zip*

Phone 3218907302

Email Jodi@FLCAN.ORG

Speaking: ☐ For ☒ Against ☐ Information
Lines 105-108

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

Representing Florida Cannabis Action Network

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

By the Committee on Health Policy; and Senator Rodriguez

588-02182-21 2021700c1

A bill to be entitled

An act relating to telehealth; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to reimburse the use of telehealth services under certain circumstances and subject to certain limitations; requiring providers to include certain documentation in patient records and notes; authorizing certain out-of-state providers to receive reimbursement for telehealth services; providing an exception; amending s. 456.47, F.S.; revising the definition of the term "telehealth"; authorizing telehealth providers to prescribe specified controlled substances through telehealth under certain circumstances; authorizing nonphysician health care practitioners to satisfy a certain supervision requirement through telehealth; amending ss. 458.347 and 459.022, F.S.; revising the definition of the term "supervision"; amending s. 465.003, F.S.; revising the definition of the term "pharmacy"; revising construction of the term "not present and on duty"; amending s. 465.014, F.S.; authorizing registered pharmacy technicians to compound and dispense medicinal drugs under certain circumstances; providing an exception to certain supervision limitations; amending s. 465.015, F.S.; providing applicability; exempting certain registered pharmacy technicians from specified prohibitions; creating s. 465.0198, F.S.; defining the term "supervising pharmacy"; providing for the permitting of remote-site pharmacies;

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

588-02182-21 2021700c1

requiring a licensed or consultant pharmacist to serve as the prescription department manager of a remote site; requiring remote-site pharmacies to notify the Department of Health of a change in the pharmacy's prescription department manager within a specified timeframe; providing requirements for remote-site pharmacies; providing that remote-site pharmacies are not considered pharmacy locations for purposes of network access in managed care programs; authorizing remote-site pharmacies to store, hold, and dispense medicinal drugs; prohibiting remote-site pharmacies from performing centralized prescription filling; requiring prescription department managers to visit remote sites, based on a certain schedule, to perform specified tasks; authorizing registered pharmacists to serve as prescription department managers for up to three remote-site pharmacies under certain circumstances; amending s. 465.022, F.S.; exempting registered pharmacists serving as prescription department managers for remote-site pharmacies from certain practice limitations; amending s. 465.0265, F.S.; providing applicability; amending s. 465.1893, F.S.; providing additional long-acting medications pharmacists may administer under certain circumstances; revising requirements for a continuing education course such pharmacists must complete; amending s. 468.1225, F.S.; revising minimum procedures and equipment requirements for fitting and selling hearing aids; amending s. 468.1265, F.S.;

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

revising a prohibition on the sale or distribution of hearing aids through the mail; amending s. 484.0501, F.S.; revising minimum procedures and equipment requirements for fitting and selling hearing aids; amending s. 484.054, F.S.; revising a prohibition on the sale or distribution of hearing aids through the mail; amending s. 893.05, F.S.; prohibiting telehealth providers from prescribing specified controlled substances through telehealth; providing an effective date.

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

Section 1. Present subsections (22) through (26) of section 409.908, Florida Statutes, are redesignated as subsections (23) through (27), respectively, and a new subsection (22) is added to that section, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate

for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(22) Subject to any limitations or directions provided in the General Appropriations Act, the agency shall reimburse the use of telehealth as defined by s. 456.47, to include services provided in real time, services provided using store-and-forward technologies, and remote patient monitoring services to the extent that these technologies are available.

(a) Providers using any modality described in this subsection must ensure that treatment services are medically necessary and performed within a provider's scope of practice and any applicable supervision requirements.

(b) Providers must include documentation regarding the use of telehealth in the medical record or progress notes for each encounter with a recipient.

(c) Out-of-state providers who are registered under s. 456.47(4) and enrolled in Florida Medicaid as an out-of-state provider may be reimbursed for telehealth services provided to recipients in this state.

(d) Reimbursement under this subsection does not cover the purchase of any general telecommunications equipment that is not specific to or used solely for the provision of telehealth, including, but not limited to, computers, tablets, cell phones, smartphones, or any other similar equipment or device.

Section 2. Paragraph (a) of subsection (1) and paragraph (c) of subsection (2) of section 456.47, Florida Statutes, are amended, and paragraph (f) is added to subsection (2) of that section, to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide or supervise the provision of 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 includes ~~does not include~~ audio-only telephone calls, personal e-mail messages, ~~or~~ facsimile transmissions, and any other nonpublic-facing telecommunications technology.

(2) PRACTICE STANDARDS.—

(c) A telehealth provider, acting within the scope of his or her practice and in accordance with chapter 893, may ~~not~~ use telehealth to prescribe a controlled substance listed in

Schedule III, Schedule IV, or Schedule V of s. 893.03 ~~unless the controlled substance is prescribed for the following:~~

~~1. The treatment of a psychiatric disorder;~~

~~2. Inpatient treatment at a hospital licensed under chapter 395;~~

~~3. The treatment of a patient receiving hospice services as defined in s. 400.601; or~~

~~4. The treatment of a resident of a nursing home facility as defined in s. 400.021~~.

(f) A nonphysician health care practitioner, including, but not limited to, an advanced practice registered nurse, a certified registered nurse anesthetist, or a physician assistant, who is required to maintain a formal supervisory relationship with a physician may satisfy such requirement through telehealth.

Section 3. Paragraph (f) of subsection (2) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

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

(f) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telehealth as defined in s. 456.47(1) ~~telecommunication~~. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

Section 4. Paragraph (f) of subsection (2) of section

459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

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

(f) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telehealth as defined in s. 456.47(1) ~~telecommunication~~. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

Section 5. Subsection (11) of section 465.003, Florida Statutes, is amended to read:

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

(11)(a) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, ~~and~~ an Internet pharmacy, and a remote-site pharmacy.

1. 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.

2. The term "institutional pharmacy" includes every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility, hereinafter referred to as "health care institutions," where medicinal drugs are compounded, dispensed, stored, or sold.

3. 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 chapter 395 or the nuclear medicine facilities of such hospitals.

4. 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.

5. 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. Any act described in this definition constitutes the practice of pharmacy as defined in subsection (13).

6. The term "remote-site pharmacy" or "remote site" includes every location where medicinal drugs are compounded or dispensed by a registered pharmacy technician who is remotely supervised by an off-site pharmacist acting in the capacity of a prescription department manager.

(b) The pharmacy department of any permittee shall be considered closed whenever a Florida licensed pharmacist is not present and on duty. The term "not present and on duty" may ~~shall~~ not be construed to prevent any of the following:

1. A pharmacist from exiting the prescription department for the purposes of consulting or responding to inquiries or providing assistance to patients or customers.

2. A pharmacist from~~,~~ attending to personal hygiene needs.

3. A pharmacist from~~, or~~ performing any other function for which the pharmacist is responsible, provided that such activities are conducted in a manner consistent with the pharmacist's responsibility to provide pharmacy services.

4. An off-site pharmacist, acting in the capacity of a prescription department manager, from remotely supervising a registered pharmacy technician at a remote-site pharmacy.

Section 6. Subsection (1) of section 465.014, Florida Statutes, is amended to read:

465.014 Pharmacy technician.—

(1) A person other than a licensed pharmacist or pharmacy intern may not engage in the practice of the profession of pharmacy, except that a licensed pharmacist may delegate to pharmacy technicians who are registered pursuant to this section those duties, tasks, and functions that do not fall within the purview of s. 465.003(13), and a registered pharmacy technician operating under remote supervision of an off-site pharmacist under s. 465.0198 may compound and dispense medicinal drugs under such supervision. All such delegated acts must be performed under the direct supervision of a licensed pharmacist who is responsible for all such acts performed by persons under his or her supervision. A registered pharmacy technician, under the supervision of a pharmacist, may initiate or receive communications with a practitioner or his or her agent, on behalf of a patient, regarding refill authorization requests. A licensed pharmacist may not supervise more than one registered pharmacy technician, except as provided in s. 465.0198 or unless otherwise permitted by the guidelines adopted by the board. The board shall establish guidelines to be followed by licensees or

permittees in determining the circumstances under which a licensed pharmacist may supervise more than one pharmacy technician.

Section 7. Paragraph (b) of subsection (1) and paragraph (b) of subsection (2) of section 465.015, Florida Statutes, are amended to read:

465.015 Violations and penalties.—

(1) It is unlawful for any person to own, operate, maintain, open, establish, conduct, or have charge of, either alone or with another person or persons, a pharmacy:

(b) In which a person not licensed as a pharmacist in this state or not registered as an intern in this state or in which an intern who is not acting under the direct and immediate personal supervision of a licensed pharmacist fills, compounds, or dispenses any prescription or dispenses medicinal drugs. This paragraph does not apply to any person who owns, operates, maintains, opens, establishes, conducts, or has charge of a remote site pursuant to s. 465.0198.

(2) It is unlawful for any person:

(b) To fill, compound, or dispense prescriptions or to dispense medicinal drugs if such person does not hold an active license as a pharmacist in this state, is not registered as an intern in this state, ~~or~~ is an intern not acting under the direct and immediate personal supervision of a licensed pharmacist, or is not a registered pharmacy technician at a remote-site pharmacy acting under remote supervision of a licensed pharmacist pursuant to s. 465.0198.

Section 8. Section 465.0198, Florida Statutes, is created to read:

465.0198 Remote-site pharmacy permits.—

(1) As used in this section, the term "supervising pharmacy" means a pharmacy licensed in this state which employs a licensed pharmacist who remotely supervises a registered pharmacy technician at a remote-site pharmacy.

(2) Any person desiring a permit to operate a remote-site pharmacy must apply to the department. If the board certifies that the application complies with the laws and rules of the board, the department must issue the permit. A permit may not be issued unless a licensed pharmacist or consultant pharmacist is designated as the prescription department manager responsible for the oversight of the remote site. The permittee must notify the department within 10 days after any change of the prescription department manager.

(3) A remote-site pharmacy must comply with all of the following:

(a) Be jointly owned by or operated under a contract with a supervising pharmacy.

(b) Maintain a video surveillance system that records continuously 24 hours per day and retain video surveillance recordings for at least 45 days.

(c) Display a sign visible to the public indicating that the location is a remote-site pharmacy and that the facility is under 24-hour video surveillance.

(d) Maintain a policies and procedures manual, which must be made available to the board or its agent upon request, and must include, but need not be limited to, all of the following:

1. A description of how the pharmacy will comply with federal and state laws and rules.

2. The procedures for supervising the remote site and counseling its patients.

3. The procedures for reviewing the prescription drug inventory and drug records maintained by the remote site.

4. The policies and procedures for providing security adequate to protect the confidentiality and integrity of patient information.

5. The written plan for recovery from an event that interrupts or prevents the prescription department manager from supervising the remote site's operation.

6. The procedures for use of the state prescription drug monitoring program by the prescription department manager before he or she may authorize the dispensing of any controlled substance.

7. The procedures for maintaining a perpetual inventory of the controlled substances listed in s. 893.03(2).

8. The specific duties, tasks, and functions that registered pharmacy technicians are authorized to perform at the remote site.

(4) A remote-site pharmacy is not considered a pharmacy location for purposes of network access in managed care programs.

(5) A remote-site pharmacy may store, hold, or dispense any medicinal drug.

(6) A remote-site pharmacy may not perform centralized prescription filling as defined in s. 465.003(16).

(7) The prescription department manager must visit the remote site, based on a schedule determined by the board, to inspect the pharmacy, address personnel matters, and provide

clinical services for patients.

(8) A registered pharmacist may serve as the prescription department manager for up to three remote-site pharmacies that are under common control of the same supervising pharmacy.

Section 9. Paragraph (c) of subsection (11) of section 465.022, Florida Statutes, is amended to read:

465.022 Pharmacies; general requirements; fees.—

(11) A permittee must notify the department of the identity of the prescription department manager within 10 days after employment. The prescription department manager must comply with the following requirements:

(c) A registered pharmacist may not serve as the prescription department manager in more than one location, except as authorized under s. 465.0198, unless approved by the board.

Section 10. Subsection (1) of section 465.0265, Florida Statutes, is amended to read:

465.0265 Centralized prescription filling.—

(1) A pharmacy licensed under this chapter may perform centralized prescription filling for another pharmacy, provided that the pharmacies have the same owner or have a written contract specifying the services to be provided by each pharmacy, the responsibilities of each pharmacy, and the manner in which the pharmacies will comply with federal and state laws, rules, and regulations. This subsection does not apply to a remote-site pharmacy.

Section 11. Section 465.1893, Florida Statutes, is amended to read

465.1893 Administration of long-acting ~~antipsychotic~~

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

medication by injection.—

(1)(a) A pharmacist, at the direction of a physician licensed under chapter 458 or chapter 459, may administer a long-acting antipsychotic medication or an extended-release medication indicated to treat opioid use disorder, alcohol use disorder, or other substance use disorder or dependency, including, but not limited to, buprenorphine, naltrexone, or other medications that have been approved by the United States Food and Drug Administration by injection to a patient if the pharmacist:

1. Is authorized by and acting within the framework of an established protocol with the prescribing physician.

2. Practices at a facility that accommodates privacy for nondeltoid injections and conforms with state rules and regulations regarding the appropriate and safe disposal of medication and medical waste.

3. Has completed the course required under subsection (2).

(b) A separate prescription from a physician is required for each injection administered by a pharmacist under this subsection.

(2)(a) A pharmacist seeking to administer a ~~long-acting antipsychotic~~ medication described in paragraph (1)(a) ~~by injection~~ must complete an 8-hour continuing education course offered by:

1. A statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award (AMA PRA) Category 1 Credit or the American Osteopathic Association (AOA) Category 1-A continuing medical

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

education (CME) credit; and

2. A statewide association of pharmacists.

(b) The course may be offered in a distance learning format and must be included in the 30 hours of continuing professional pharmaceutical education required under s. 465.009(1). The course shall have a curriculum of instruction that concerns the safe and effective administration of behavioral health, addiction, and antipsychotic medications by injection, including, but not limited to, potential allergic reactions to such medications.

Section 12. Subsections (1) through (4) of section 468.1225, Florida Statutes, are amended to read:

468.1225 Procedures, equipment, and protocols.—

(1) The following minimal procedures must ~~shall~~ be used when a licensed audiologist fits and sells a hearing aid unless the client is 18 years of age or older and provides a medical clearance or a waiver of medical examination:

(a) Pure tone audiometric testing by air and bone to determine the type and degree of hearing deficiency when indicated.

(b) Effective masking when indicated.

(c) Appropriate testing to determine speech reception thresholds, speech discrimination scores, the most comfortable listening levels, uncomfortable loudness levels, and the selection of the best fitting arrangement for maximum hearing aid benefit when indicated.

(2) The following equipment must ~~shall~~ be used unless the client is 18 years of age or older and provides a medical clearance or a waiver of medical examination:

(a) A wide range audiometer that ~~which~~ meets the specifications of the American National Standards Institute for diagnostic audiometers when indicated.

(b) A speech audiometer or a master hearing aid in order to determine the most comfortable listening level and speech discrimination when indicated.

(3) A final fitting ensuring physical and operational comfort of the hearing aid must ~~shall~~ be made when indicated.

(4) A licensed audiologist who fits and sells hearing aids must ~~shall~~ obtain the following medical clearance: If, upon inspection of the ear canal with an otoscope in the common procedure of fitting a hearing aid or ~~and~~ upon interrogation of the client, there is any recent history of infection or any observable anomaly, the client must ~~shall~~ be instructed to see a physician, and a hearing aid may ~~shall~~ not be fitted until medical clearance is obtained for the condition noted. If, upon return, the condition noted is no longer observable and the client signs a medical waiver, a hearing aid may be fitted. Any person with a significant difference between bone conduction hearing and air conduction hearing must be informed of the possibility of medical or surgical correction.

Section 13. Section 468.1265, Florida Statutes, is amended to read:

468.1265 Sale or distribution of hearing aids through mail; penalty.—It is unlawful for any person to sell or distribute hearing aids through the mail to the ultimate consumer who is younger than 18 years of age. Any person who violates this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 14. Subsections (1) through (4) of section 484.0501, Florida Statutes, are amended to read:

484.0501 Minimal procedures and equipment.—

(1) The following minimal procedures must ~~shall~~ be used in the fitting and selling of hearing aids unless the client is 18 years of age or older and provides a medical clearance or a waiver of medical examination:

(a) Pure tone audiometric testing by air and bone to determine the type and degree of hearing deficiency.

(b) Effective masking when indicated.

(c) Appropriate testing to determine speech reception thresholds, speech discrimination scores, the most comfortable listening levels, uncomfortable loudness levels, and the selection of the best fitting arrangement for maximum hearing aid benefit.

(2) The following equipment must ~~shall~~ be used unless the client is 18 years of age or older and provides a medical clearance or a waiver of medical examination:

(a) A wide range audiometer that ~~which~~ meets the specifications of the American National Standards Institute for diagnostic audiometers.

(b) A speech audiometer or a master hearing aid in order to determine the most comfortable listening level and speech discrimination.

(3) For clients younger than 18 years of age, a final fitting ensuring physical and operational comfort of the hearing aid must ~~shall~~ be made. For all other clients, such final fitting must be made when indicated.

(4) The following medical clearance must ~~shall~~ be obtained:

If, upon inspection of the ear canal with an otoscope in the common procedure of a hearing aid fitter or ~~and~~ upon interrogation of the client, there is any recent history of infection or any observable anomaly, the client must ~~shall~~ be instructed to see a physician, and a hearing aid may ~~shall~~ not be fitted until medical clearance is obtained for the condition noted. If, upon return, the condition noted is no longer observable and the client signs a medical waiver, a hearing aid may be fitted. Any person with a significant difference between bone conduction hearing and air conduction hearing must be informed of the possibility of medical correction.

Section 15. Section 484.054, Florida Statutes, is amended to read:

484.054 Sale or distribution of hearing aids through mail; penalty.—It is unlawful for any person to sell or distribute hearing aids through the mail to the ultimate consumer who is younger than 18 years of age. Any violation of this section constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 16. Paragraph (e) is added to subsection (1) of section 893.05, Florida Statutes, to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1)

(e) A telehealth provider as defined in s. 456.47 may not prescribe through telehealth a controlled substance listed in Schedule I or Schedule II of s. 893.03.

Section 17. This act shall take effect July 1, 2021.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
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Appropriations Subcommittee on Health and Human Services (Rodriguez) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present paragraph (e) of subsection (14) of section 409.908, Florida Statutes, is redesignated as paragraph (f), present subsections (22) through (26) of that section are redesignated as subsections (23) through (27), respectively, a new paragraph (e) is added to subsection (14) of that section, and a new subsection (22) is added to that section, to read:

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

(14) A provider of prescribed drugs shall be reimbursed the

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least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The Medicaid maximum allowable fee for ingredient cost must be based on the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

(e) A pharmacist providing health care services through telehealth as defined in s. 456.47 shall be reimbursed for such services in accordance with this subsection.

(22) Subject to any limitations or directions provided in the General Appropriations Act, the agency shall reimburse the use of telehealth as defined by s. 456.47, including services provided in real time, services provided using store-and-forward technologies, and remote patient monitoring services to the extent that these technologies are available.

(a) Providers using any modality described in this subsection must ensure that treatment services are medically necessary and performed within a provider's scope of practice and any applicable supervision requirements.

(b) Providers must include documentation regarding the use of telehealth in the medical record or progress notes for each encounter with a recipient.

(c) Out-of-state providers who are registered under s. 456.47(4) and enrolled in Florida Medicaid as an out-of-state provider may be reimbursed for telehealth services provided to recipients in this state.


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(d) Reimbursement under this subsection does not cover the purchase of any general telecommunications equipment that is not specific to or used solely for the provision of telehealth, including, but not limited to, computers, tablets, cell phones, smartphones, or any other similar equipment or device.

Section 2. Paragraph (a) of subsection (1) and paragraph (c) of subsection (2) of section 456.47, Florida Statutes, are amended to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide or supervise the provision of 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 includes ~~does not include~~ audio-only telephone calls, personal e-mail messages, ~~or~~ facsimile transmissions, and any other nonpublic-facing telecommunications technology.

(2) PRACTICE STANDARDS.—

(c) A telehealth provider, acting within the scope of his or her practice and in accordance with chapter 893, may ~~not~~ use telehealth to prescribe a controlled substance listed in Schedule III, Schedule IV, or Schedule V of s. 893.03 and may use telehealth to prescribe a controlled substance listed in Schedule II of s. 893.03 if ~~unless~~ the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

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2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

A telehealth provider may not use telehealth to prescribe a controlled substance listed in Schedule I of s. 893.03 or to issue a physician certification for marijuana for medical use under s. 381.986.

Section 3. Paragraph (f) of subsection (2) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

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

(f) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telehealth as defined in s. 456.47 ~~telecommunication~~. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

Section 4. Paragraph (f) of subsection (2) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

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

(f) "Supervision" means responsible supervision and


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control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telehealth as defined in s. 456.47 ~~telecommunication~~. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

Section 5. Section 465.1893, Florida Statutes, is amended to read

465.1893 Administration of long-acting ~~antipsychotic~~ medication by injection.—

(1)(a) A pharmacist, at the direction of a physician licensed under chapter 458 or chapter 459, may administer a long-acting antipsychotic medication or an extended-release medication indicated to treat opioid use disorder, alcohol use disorder, or other substance use disorder or dependency, including, but not limited to, buprenorphine, naltrexone, or other medications that have been approved by the United States Food and Drug Administration by injection to a patient if the pharmacist:

1. Is authorized by and acting within the framework of an established protocol with the prescribing physician.

2. Practices at a facility that accommodates privacy for nondeltoid injections and conforms with state rules and regulations regarding the appropriate and safe disposal of medication and medical waste.

3. Has completed the course required under subsection (2).

(b) A separate prescription from a physician is required


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for each injection administered by a pharmacist under this subsection.

(2)(a) A pharmacist seeking to administer a ~~long-acting antipsychotic~~ medication described in paragraph (1)(a) ~~by injection~~ must complete an 8-hour continuing education course offered by:

1. A statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award (AMA PRA) Category 1 Credit or the American Osteopathic Association (AOA) Category 1-A continuing medical education (CME) credit; and

2. A statewide association of pharmacists.

(b) The course may be offered in a distance learning format and must be included in the 30 hours of continuing professional pharmaceutical education required under s. 465.009(1). The course shall have a curriculum of instruction that concerns the safe and effective administration of behavioral health, addiction, and antipsychotic medications by injection, including, but not limited to, potential allergic reactions to such medications.

Section 6. Paragraph (e) is added to subsection (1) of section 893.05, Florida Statutes, to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1)

(e) A telehealth provider as defined in s. 456.47 may not prescribe through telehealth a controlled substance listed in Schedule I or Schedule II of s. 893.03.


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Section 7. This act shall take effect July 1, 2021.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to telehealth; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to reimburse pharmacists for health care services provided through telehealth; requiring the agency to reimburse the use of telehealth services under certain circumstances and subject to certain limitations; requiring providers to include certain documentation in patient records and notes; authorizing certain out-of-state providers to receive reimbursement for telehealth services; providing an exception; amending s. 456.47, F.S.; revising the definition of the term "telehealth"; authorizing telehealth providers to prescribe specified controlled substances through telehealth under certain circumstances; amending ss. 458.347 and 459.022, F.S.; revising the definition of the term "supervision"; amending s. 465.1893, F.S.; providing additional long-acting medications pharmacists may administer under certain circumstances; revising requirements for a continuing education course such pharmacists must complete; amending s. 893.05, F.S.; prohibiting telehealth providers from prescribing specified

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controlled substances through telehealth; providing an effective date.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
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Appropriations Subcommittee on Health and Human Services (Brodeur) recommended the following:

Senate Amendment to Amendment (645592) (with directory and title amendments)

Between lines 108 and 109
insert:

(6) EXEMPTIONS.—A health care professional who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another state or jurisdiction, and who provides health care services using telehealth to a patient located in this state, is

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not subject to the registration requirement under this section if the services are provided:

(a) In response to an emergency medical condition as defined in s. 395.002; or

(b) In consultation with a health care professional licensed in this state who has ~~ultimate~~ authority over the diagnosis and care of the patient.

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

And the directory clause is amended as follows:

Delete lines 74 - 75

and insert:

Section 2. Paragraph (a) of subsection (1), paragraph (c) of subsection (2), and subsection (6) of section 456.47, Florida Statutes, are

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

And the title is amended as follows:

Delete line 206

and insert:

circumstances; revising an exemption from telehealth registration requirements; amending ss. 458.347 and 459.022, F.S.;

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
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Appropriations Subcommittee on Health and Human Services (Rodriguez) recommended the following:

Senate Amendment to Amendment (645592) (with title amendment)

Between lines 134 and 135

insert:

Section 5. Paragraph (a) of subsection (11) of section 465.003, Florida Statutes, is amended to read

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

(11)(a) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy,

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~~and~~ an Internet pharmacy, and a remote-site pharmacy.

1. 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.

2. The term "institutional pharmacy" includes every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility, hereinafter referred to as "health care institutions," where medicinal drugs are compounded, dispensed, stored, or sold.

3. 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 chapter 395 or the nuclear medicine facilities of such hospitals.

4. 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.

5. 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. Any act described in this definition constitutes the practice of pharmacy as defined in subsection (13).

6. The term "remote-site pharmacy" or "remote site"

includes every location within a community mental health center or clinic as defined in s. 394.455 in which medicinal drugs are compounded or dispensed by a registered pharmacy technician who is remotely supervised by an off-site pharmacist acting in the capacity of a prescription department manager.

Section 6. Section 465.0198, Florida Statutes, is created to read:

465.0198 Remote-site pharmacy permits.—

(1) As used in this section, the term "supervising pharmacy" means a pharmacy licensed in this state which employs a licensed pharmacist who remotely supervises a registered pharmacy technician at a remote-site pharmacy.

(2) Any person desiring a permit to operate a remote-site pharmacy must apply to the department. If the board certifies that the application complies with the laws and rules of the board, the department must issue the permit. A permit may not be issued unless a licensed pharmacist or consultant pharmacist is designated as the prescription department manager responsible for the oversight of the remote site. The permittee must notify the department within 10 days after any change of the prescription department manager.

(3) A remote-site pharmacy must comply with all of the following:

(a) Be jointly owned by or operated under a contract with a supervising pharmacy.

(b) Maintain a video surveillance system that records continuously 24 hours per day and retain video surveillance recordings for at least 45 days.

(c) Display a sign visible to the public indicating that


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the location is a remote-site pharmacy and that the facility is under 24-hour video surveillance.

(d) Maintain a policies and procedures manual, which must be made available to the board or its agent upon request, and must include, but need not be limited to, all of the following:

1. A description of how the pharmacy will comply with federal and state laws and rules.

2. The procedures for supervising the remote site and counseling its patients.

3. The procedures for reviewing the prescription drug inventory and drug records maintained by the remote site.

4. The policies and procedures for providing security adequate to protect the confidentiality and integrity of patient information.

5. The written plan for recovery from an event that interrupts or prevents the prescription department manager from supervising the remote site’s operation.

6. The procedures for use of the state prescription drug monitoring program by the prescription department manager before he or she may authorize the dispensing of any controlled substance.

7. The procedures for maintaining a perpetual inventory of the controlled substances listed in s. 893.03(2).

8. The specific duties, tasks, and functions that registered pharmacy technicians are authorized to perform at the remote site.

(4) A remote-site pharmacy is not considered a pharmacy location for purposes of network access in managed care programs.


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(5) A remote-site pharmacy may store, hold, or dispense any medicinal drug.

(6) A remote-site pharmacy may not perform centralized prescription filling as defined in s. 465.003(16).

(7) The prescription department manager must visit the remote site, based on a schedule determined by the board, to inspect the pharmacy, address personnel matters, and provide clinical services for patients.

(8) A registered pharmacist may serve as the prescription department manager for up to three remote-site pharmacies that are under common control of the same supervising pharmacy.

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

And the title is amended as follows:

Between lines 207 and 208

insert:

amending s. 465.003, F.S.; revising the definition of the term "pharmacy"; creating s. 465.0198, F.S.; defining the term "supervising pharmacy"; providing for the permitting of remote-site pharmacies; requiring a licensed or consultant pharmacist to serve as the prescription department manager of a remote site; requiring remote-site pharmacies to notify the Department of Health of a change in the pharmacy's prescription department manager within a specified timeframe; providing requirements for remote-site pharmacies; providing that remote-site pharmacies are not considered pharmacy locations for purposes of network access in managed care programs; authorizing

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remote-site pharmacies to store, hold, and dispense medicinal drugs; prohibiting remote-site pharmacies from performing centralized prescription filling; requiring prescription department managers to visit remote sites, based on a certain schedule, to perform specified tasks; authorizing registered pharmacists to serve as prescription department managers for up to three remote-site pharmacies under certain circumstances;

867884

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (645592) (with title amendment)

Delete lines 177 - 184.

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

And the title is amended as follows:

Delete lines 212 - 214

and insert:

complete; providing an

406586

LEGISLATIVE ACTION

Senate	.	House
Comm: OO	.	
04/08/2021	.	
	.	
	.	
	.	

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

Senate Amendment (with directory and title amendments)

Between lines 160 and 161

insert:

(6) EXEMPTIONS.—A health care professional who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another state or jurisdiction, and who provides health care services using telehealth to a patient located in this state, is not subject to the registration requirement under this section

406586

if the services are provided:

(a) In response to an emergency medical condition as defined in s. 395.002; or

(b) In consultation with a health care professional licensed in this state who has ~~ultimate~~ authority over the diagnosis and care of the patient.

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

And the directory clause is amended as follows:

Delete lines 126 - 127

and insert:

Section 2. Paragraph (a) of subsection (1), paragraph (c) of subsection (2), and subsection (6) of section 456.47, Florida Statutes, are

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

And the title is amended as follows:

Delete line 16

and insert:

requirement through telehealth; revising an exemption from telehealth registration requirements; amending ss. 458.347

172640

LEGISLATIVE ACTION

Senate	.	House
Comm: OO	.	
04/08/2021	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 417 - 512.

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

And the title is amended as follows:

Delete lines 56 - 65

and insert:

amending s. 893.05, F.S.; prohibiting telehealth

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 894 (282916)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Diaz
SUBJECT:	Physician Assistants
DATE:	April 12, 2021 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 894 expands the scope of practice of physician assistants by allowing them to:

- Prescribe psychiatric mental health controlled substances to minors under certain circumstances;
- Procure certain medical equipment and devices;
- Supervise medical assistants; and
- Sign and certify documents that currently require a physician's signatures such as Baker Act commitments, do-not-resuscitate orders, school physicals, and death certificates.

The bill also authorizes physician assistants to directly bill for and receive payments from public and private insurance companies for the services they deliver.

Current law limits the number of physician assistants a physician can supervise to four. The bill expands the number of PAs that a physician can supervise to 10.

The fiscal impact of the bill is indeterminate, see Section V.

The bill takes effect on July 1, 2021.

II. Present Situation:

Physician Assistants (PAs)

History of the Physician Assistant Profession

In 1965 physicians and educators recognized there was a shortage of primary care physicians, so Duke University Medical Center, put together the first class of PAs. Duke selected four Navy Vietnam-era hospital corpsmen who had received considerable medical training during their military service. The first PA class graduated from the Duke program in 1967.[1]

In Florida, physicians were first authorized to use PAs in their practice in 1979. The legislative intent for recognizing the PA profession was to allow physicians to delegate the performance of "medical services" to qualified PAs when such delegation was consistent with the patient's health and welfare; freeing physicians to more effectively utilize their medical education, training, and experience. Physicians were required to apply to their board[2] to utilize and supervise a PA in their practice. PAs were required to be graduates of board-approved programs, or the equivalent, and to be approved by the Department of Health (DOH) to perform "medical services" under the supervision of a physician, who was certified by the board to supervise the PA. PAs were not required to be licensed by the DOH. Physicians utilizing PAs were liable for any act or omissions of the PAs while under the physician's supervision.[3]

Physician Assistant Education

Physician assistant programs must be recommended by the Council on PAs and approved by the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) (collectively known as the boards). The council may only recommend PA programs that hold full accreditation or provisional accreditation from the Commission on Accreditation of Allied Health Programs or its successor organization. The boards are required to adopt program standards to ensure the health and welfare of patients that receive PA services, and review curricula, faculties, and facilities of PA programs to ensure they meet standards set forth by the boards.[4]

Currently, there are 17 universities in Florida offering PA programs accredited by the Accreditation Review Commission on Education (ARC-PA).[5] Physician Assistant programs are on average 24 to 27 months, or six or seven semesters, requiring 96 to 111 plus clinical and classroom credit hours to graduate. The programs are designed to prepare students to practice as part of a Physician-PA team. Upon completion, graduates receive a Master of Science in PA Practice degree or a Master of PA Studies, or similar degree.

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[1] American Association of Physician Assistants, About, History, *History of the PA Profession*, *available at* https://www.aapa.org/about/history/ (last visited Mar. 5, 2021).
[2] Section 456.001(1), F.S., defines "board" as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the Department of Health or, in some cases, within the department's Division of Medical Quality Assurance.
[3] Chapter 79-230, s. 1., and ch. 79-320, s. 1., Laws of Fla. (Creating ss. 459.018 and 458.017, F.S., effective Jul. 1, 1979).
[4] Section 458.347(6) and 459.022(6), F.S.
[5] Florida Academy of PAs, *For Students - PA Programs in Florida*, *available at* https://www.fapaonline.org/page/studentprograms (last visited Mar. 4, 2021).

Following graduation, a PA candidate must take and pass the PA National Certifying Examination (PANCE) given by the National Commission on Certification of PAs (NCCPA) to become certified. It is a five-hour exam with 300 multiple-choice questions, with no didactic components.[6]

The Council of Physician Assistants

Physician Assistants are regulated within the DOH by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine (BOM) for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (BOOM) for PAs licensed under ch. 459, F.S.[7]

The Council consists of five members:[8]

- One physician who is a member of the BOM who supervises a PA in his or her practice;
- One physician who is a member of the BOOM who supervises a PA in his or her practice; and
- Three PAs licensed under chs. 458 or 459, F.S.

The Council is responsible for:[9]

- Recommending PAs to the DOH for licensure;
- Developing rules for the boards' consideration regulating the use of PAs by physicians;
- Developing rules to ensure the continuity of supervision in each practice setting;
- Making recommendations to the boards on matters relating to PAs;
- Addressing the concerns and problems of practicing PAs in order to improve safety in the clinical practices of PAs;
- Denying, restricting, or placing conditions on the license of a PA who fails to meet the licensing requirements;[10] and
- Establishing's a formulary of medicinal drugs that a PA may not prescribe (negative formulary).[11]

Physician Assistant Licensure

An applicant for a PA license must be at least 18 years of age. The DOH must issue a license to a person who has been certified by the Council as having met all of the following requirements:[12]

- Completed aboard-approved PA training program;
- Obtained a passing score on the NCCPA proficiency exam;
- Acknowledged any prior felony convictions;

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[6] The National Commission on Certification of PA (NCCPA), Become Certified, *Becoming Certified, available at* https://www.nccpa.net/BecomingCertified (last visited Mar. 4, 2021). The NCCPA is the only certifying organization for PAs in the United States. As of Dec. 31, 2020, there were approximately 148,500 certified PAs in the United States.
[7] Sections 458.347 and 459. 022, F.S.
[8] Sections 458.347(9) and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. *See* ss. 458.307 and 459.004, F.S., respectively.
[9] Sections 458.347(9)(c) and 459.022(9)(c), F.S.
[10] Sections 458.347(9)(d) and 459. 022(9)(d), F.S.
[11] Section 458.347(4)(f), F.S.
[12] Sections 458.347(7) and 459.022(7), F.S.

- Submitted to a background screening and have no disqualifying offenses;[13]
- Acknowledged any previous revocation or denial of licensure in any state; and
- Provided a copy of course transcripts and a copy of the course descriptions from the PA's training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

Physician Assistants must renew their licenses biennially. During each biennial renewal cycle, a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the NCCPA.[14] To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially, and must take and pass a re-certification examination every 10 years.[15]

Physician Assistant Scope of Practice and Physician Supervision

Physician assistants may only practice under the direct or indirect supervision of a physician with whom they have a working relationship.[16] Physician Assistants are licensed to perform only those medical services delegated to them by a supervising allopathic or osteopathic physician.[17]

A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice. A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on his or her reasonable medical judgment regarding the probability of morbidity and mortality to the patient, and the physician must be certain the PA has the knowledge and skills to perform the task or procedure assigned.[18]

Current law requires a supervising physician to exercise "responsible supervision" and control and, except in cases of emergency, requires the easy availability[19] or physical presence of the physician for consultation and direction of the actions of the PA. The BOM and BOOM establish rules as to what constitutes responsible supervision of a PA.[20]

The boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate is dependent upon the:
- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;

[13] Section 456.0135, F.S.
[14] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[15] National Commission on Certification of Physician Assistants, *Maintaining Certification*, *available at* https://www.nccpa.net/CertificationProcess (last visited Mar. 4, 2021).
[16] Sections 458.347(2)(f) and 459.022(2)(f), F.S.
[17] Sections 458.347(4) and 459.022(4), F.S.
[18] Fla. Adm. Code R. 64B8-30.012(2) and 64B15-6.010(2).
[19] The term "easy availability" includes the ability to communicate by way of telecommunication.
[20] Sections 458.347(2)(f) and 459.022(2)(f), F.S.

- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.[21]

Responsible supervision and control also require the supervising physician to periodically review the PA's performance[22] and to determine the level of supervision the PA requires for every task or procedure delegated to the PA as to whether it will be under:[23]

- *Direct supervision:* Requires the physical presence of the supervising physician on the premises so that the physician is immediately available to the PA when needed; or
- *Indirect supervision:* Requires the supervising physician to be within reasonable physical proximity, and easily availability, to the PA for communication with the PA, including via telecommunication.

A supervising physician may also delegate to a PA his or her authority to:[24]

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the negative formulary established by the Council, but only under the following circumstances:
  - The PA identifies himself or herself as a PA and advises the patient of his or her right to see a physician before the prescription is written or dispensed;
  - The supervising physician must be registered as a dispensing practitioner and have notified the DOH on an approved form of his or her intent to delegate prescriptive authority or to change prescriptive authority; and
  - The PA must have completed 10 hours of continuing medical education in the specialty practice in which the PA has prescriptive authority with each licensure renewal, and three of the 10 hours must be on the safe and effective prescribing of controlled substances.
- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under ch. 395, F.S., or a nursing home licensed under Part II, ch. 400, F.S.; and
- Perform any other service that is not expressly prohibited in the PA Practice Acts, or the rules adopted thereunder.

Current law prohibits PAs licensed under the BOM from prescribing general anesthetics, radiographic contrast materials, and psychiatric mental health controlled substances to children under 18 years of age and limits their prescribing authority of schedule II controlled substances to 7 days.[25]

The DOH is authorized to issue a prescriber number to each PA who has been delegated prescribing authority by a supervising physician. The prescriber number grants authority for the prescribing of medicinal drugs, and creates a presumption that the PA is authorized to prescribe the drug and that the prescription is valid.

[21] Fla. Admin. Code R. 64B8-30.001 and 64B15-6.001.
[22] Fla. Adm. Code R. 64B8-30.001(3) and 64B15-6.001(3) (2021).
[23] Fla. Adm. Code R. 64B8-30.001(4) and (5) and 64B15-6.001(4) and (5).
[24] Sections 458.347(4) and 459.022(4), F.S.
[25] Section 458.347(4)(f)1., F.S.

A supervising physician is responsible and liable for any acts or omissions of the PAs he or she supervises and may not supervise more than four PAs at any time.[26]

Upon employment as a PA, a licensed PA must notify the DOH of his or her supervising physician in writing within 30 days after such employment or after any subsequent changes of his or her supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.[27]

Reimbursement for PA Services: Medicare

Medicare generally reimburses for medical and surgical services provided by PAs at 85 percent of the physician fee schedule. This rate generally applies to all practice settings, including hospitals, nursing facilities, homes, offices, and clinics. However, when acting as a surgical assistant, the PA's reimbursement rate is only 13.6 percent of the primary surgeon's allowable fee, and no payment is made for a PAs assisting at surgery at an approved and accredited teaching hospital unless no residents are available, the surgeon does not use residents with his patients, or trauma surgery is required. To be eligible for Medicare reimbursement for PA services, a PA must:

- Graduate from an accredited PA program or passed the national certification exam;
- Be state-licensed;
- Obtain a National Provider Identifier (NPI);[28] and
- Enroll in Medicare through the Medicare electronic enrollment system.[29]

Under Medicare, a PA's required level of supervision for reimbursement generally requires access to the collaborating physician or supervising physician by reliable electronic communication. Personal presence of the physician is generally not required. Medicare policies will not override state law guidelines or facility policies.[30] Medicare does allow PAs to submit claims under their own NPI as the rendering provider, but does not allow PAs to directly bill (receive payment directly) for covered Medicare services.[31] Reimbursement is made to the PA's employer.[32]

Notable restrictions on a PA's scope of practice under Medicare include:

- PAs may not order home health services or sign a patient's home health plan of care;
- PAs may not perform the initial comprehensive visit for patients in skilled nursing facilities;

[26] Sections 458.347(15) and 459.022(15), F.S.
[27] Sections 458.458.347(7) and 459.022(7), F.S.
[28] An NPI is a unique identification number for covered health care providers that can be shared with other providers and health plans, and is used for billing purposes. Centers for Medicare and Medicaid Services, *National Provider Identifier Standard (NPI), available at* https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand (last visited March 25, 2021).
[29] American Association of Physician Assistants, *Basic Concepts of Reimbursement: a Primer, available at* https://www.aapa.org/wp-content/uploads/2018/04/WEB-18.066-Program-Director-Page-Redesign-Reimbursement-101-v2.pdf (last viewed Mar. 8, 2021).
[30] *Id.*
[31] *See* 42 U.S.C. 1395u(b)(6)(C), 2021, which will allow services provided by PAs to be directly billed and paid to PAs only when no other facility or provider services are billed the same day after Jan. 1, 2022.
[32] American Association of Physician Assistants, *Basic Concepts of Reimbursement: a Primer, available at* https://www.aapa.org/wp-content/uploads/2018/04/WEB-18.066-Program-Director-Page-Redesign-Reimbursement-101-v2.pdf (last viewed Mar. 8, 2021).

- PAs are not reimbursed for certifying terminal illness; and
- PAs may not delegate the performance of diagnostic tests requiring direct or personal supervision of ancillary staff.[33]

Reimbursement for PA Services: Medicaid

Unlike the Medicare program, which has federal laws mandating the coverage of medical services provided by PAs, the state determines whether PAs are eligible providers under its Medicaid program and which services PAs are able to provide. In Florida, if a PA performs a service for a Medicaid enrollee, the PA must have his or her own Medicaid provider number, and the service must be billed using the PA's provider number unless the physician performs the majority of the service.[34] Medicaid services provided by a PA within his or her scope of practice may be billed under a physician's Medicaid provider number when the physician is in the building and able to render assistance as needed. These services are reimbursed at the physician-allowable amount. Services provided within the PA's scope of practice that are performed when the physician is not in the building must be billed under the rendering PA's Medicaid provider number and are reimbursed at 80 percent of the allowable amount.[35]

Reimbursement for PA Services: Commercial Health Insurance

Commercial insurers have varying policies regarding billing and reimbursement of services provided by a PA. Many choose not to enroll PAs as providers and require PAs to bill under the physicians' Medicaid number. For those that enroll PAs, billing and coverage policies must be clearly ascertained by every individual practice for every individual payer with whom they contract.[36]

III. Effect of Proposed Changes:

The bill revises the practice acts for PAs in chs. 458 and 459, F.S.

Physician Assistant Education

Currently, board-approved PA programs must be accredited by the Commission on Accreditation of Allied Health Programs. The bill amends the list of accrediting entities that PA programs must be accredited by in order to be an "approved program," to include:

- The Accreditation Review Commission on Education for the Physician Assistant or its successor entity; or
- Before 2001:
  - The Committee on Allied Health Education and Accreditation; or

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[33] *Id.*
[34] Agency for Health Care Administration, *Florida Medicare Provider Reimbursement Handbook, available at* https://ahca.myflorida.com/medicaid/review/Reimbursement/RH_08_080701_CMS-1500_ver1_4.pdf (last visited Mar. 8, 2021).
[35] Agency for Health Care Administration, *Practitioner Fee Schedule, available at* https://ahca.myflorida.com/medicaid/review/Reimbursement/2020-01-01_Fee_Sched_Billing_Codes/Practitioner_Fee_Schedule_2020.pdf (last visited Mar. 15, 2021).
[36] American Association of Physician Assistants, *Basic Concepts of Reimbursement: a Primer, available at* https://www.aapa.org/wp-content/uploads/2018/04/WEB-18.066-Program-Director-Page-Redesign-Reimbursement-101-v2.pdf (last viewed Mar. 8, 2021).

- The Commission on Accreditation of Allied Health Programs.

The bill repeals current law that requires the BOM and BOOM to adopt standards to ensure that PA programs operate in a manner that does not endanger the health or welfare of patients who receive PA services, and repeals the boards' responsibility to review the quality of the curricula, faculties, and facilities of PA programs.

Physician Assistant Licensure

Currently, to obtain licensure a PA must have a certificate of completion of a board approved PA training program and pass an entry-level proficiency exam. To obtain licensure as a PA, the bill requires a PA to graduate from an approved program accredited by the Accreditation Review Commission on Education for the PA, and submit a diploma from the approved program with their application. The bill also clarifies that a PA must obtain a passing score on the physician assistant national certifying examination (PANCE).

The bill also amends the following licensure requirements for applicants who graduated:
- After December 31, 2020, a master's degree from an approved program;
- Before January 1, 2020, a bachelor's or master's degree from an approved program;
- Before July 1, 1994, graduation from an approved program of instruction in primary health care or surgery;
- Before July 1, 1983, a certification as a PA by the boards; and
- For applicants who do not meet any of the educational requirements specified above, but who have passed the PANCE examination administered by the NCCPA before 1986, the board may also grant a license.

The bill repeals the following items that applicants must submit with their application for licensure:
- A PA program verification form; and
- A copy of course transcripts and course descriptions from the PA program describing course content in pharmacotherapy, if the applicant intends to apply for prescribing authority.

Physician Assistant Scope of Practice and Physician Supervision

The bill expands the scope of practice of PAs and authorizes PA's to:
- Prescribe Schedule II psychiatric mental health controlled substances to minors. PAs may only prescribe a 14-day supply of these controlled substances and only if the PA is under the supervision of a pediatrician, family practice physician, or psychiatrist;
- Procure medical devices and drugs unless listed in the negative formulary established by the Council and adopted by the BOM and the BOOM;
- Supervise medical assistants;[37]
- Authenticate documents with their signature, certification, stamp, verification, affidavit, or endorsement if it may be authenticated by a physician's signature, certification, stamp,

[37] Section 458.3485, F.S., defines a "medical assistant" as a professional multi-skilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician.

verification, affidavit, or endorsement, except for certifications for the medical use of marijuana. Such documents include, but are not limited to, the following:
  - Initiation of an involuntary examination under the Baker Act;[38]
  - Do-not-resuscitate (DNR) orders or orders for life-sustaining treatment;
  - Death certificates;
  - School physical examinations;
  - Medical examinations for workers' compensation claims, except medical examinations required for the evaluation and assignment of the claimants date of maximum medical improvement as defined in s. 440.02, F.S., and for any impairment ratings under s. 440.15, F.S.;[39]
  - Orders for:
    - Physical therapy;
    - Occupational therapy;
    - Speech-language therapy;
    - Home health services; and
    - Durable medical equipment.
- File the certificate of death or fetal death in the absence of a funeral director; and
- Correct a permanent death certificate.

The bill makes conforming changes to the sections of current law relating to the involuntary examinations under the Baker Act and the signing of DNR orders.

Current law limits the number of PAs a physician may supervise to four. The bill increases the number of PAs a physician may supervise to 10. The bill also deletes the following requirements:
- PAs must inform patients that they have the right to see a physician before a prescription is prescribed or dispensed by the PA; and
- PAs must notify the DOH within 30 days of employment or after any change in their supervising physician.

The bill removes from current law:
- Obsolete language related to prescriber numbers; and
- The presumption that the inclusion of the PA prescriber number on a prescription indicates the PA is authorized to prescribe the medicinal drug and that the prescription is valid.

Reimbursement for PA Services

The bill authorizes PAs to directly bill and receive payment from public and private insurance companies for services rendered.

The bill takes effect on July 1, 2021.

[38] Section 394.463, F.S.
[39] Under s. 440.02(10), F.S., the "date of maximum medical improvement" means the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

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:

The fiscal impact of PCS/CS/SB 894 is indeterminate. The bill may have a positive fiscal impact on health insurers who can reimburse for services provided by PA at a lower rate than if those same services are provided by a physician. However, to the extent that the bill's provisions, relating to physician supervision and PA scope of practice, increase access to health care services the bill may have a negative fiscal impact on health insurers who provide coverage for those services.

C. Government Sector Impact:

The fiscal impact of the bill is indeterminate. The bill may have a positive fiscal impact on health insurers who reimburse for services provided by PA at a lower rate than if those same services are provided by a physician. However, to the extent that the bill's provisions, relating to physician supervision and PA scope of practice, increase access to health care services the bill may have a negative fiscal impact on health insurers who provide coverage for those services.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill authorizes PAs to bill for and receive direct payment for the services they deliver. However:

- Nothing in the bill requires public or private insurers to pay PAs directly for those services;
- Health insurance policies, and contracts with providers, are negotiated between the parties involved and they dictate how and to whom payment for services and benefits are made, in accordance with the provisions of the policy or contract;
- Any insurer who has contracted with a preferred provider for the delivery of health care services to its insureds must make payments directly to the preferred provider for such services, and insurers traditionally contract with supervising physicians and include PA services, not directly with PAs;[40] and
- Workers' compensation carriers do not pay PAs directly, as they are not authorized under workers' compensation law.[41]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.347, 459.022, 382.008, 394.463, and 401.45.

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 April 8, 2021:
The CS:

- Expands the number of PAs that a physician can supervise to 10.
- Reverts back to current law and clarifies that PA charts do not need to be reviewed or co-signed by the supervising physician.
- Reverts back to current law that requires the supervising physicians name on PA prescriptions.
- Authorizes PAs to prescribe a 14 day supply of Schedule II psychiatric mental health controlled substances for children under 18 provided the PA is under the supervision of a pediatrician, family practice physician, or psychiatrist.
- Excludes medical use marijuana certifications from the list of documents that a PA can authenticate with their signature, certification, stamp, verification, affidavits, or endorsement.
- Clarifies that PAs may authenticate medical examinations for workers' compensation claims, except for the medical examination(s) required for the evaluation and assignment of the claimant's date of MMI and impairment rating, if any.

- Deletes references to medical assistants being regulated under ch. 459, F.S. Medical assistants are defined and regulated under ch. 458, F.S.

CS by Health Policy on March 17, 2021:
The CS eliminates certain provisions from the underlying bill, including authority for PAs to practice primary care autonomously, after meeting certain requirements, without physician supervision, and other provisions, including:

- The legislative intent for PAs to practice medicine;
- A provision to prohibit PAs from authenticating certifications for a patient to use medical marijuana;
- A requirement that for PAs to authenticate death certificates, the PA must have had training on the completion of death certificates; and
- A requirement that applicants for a PA licensure must submit:
  - A PA program verification form; and
  - An evidence-quality copy of course transcripts and a copy of the course description from a PA training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority.

The CS inserts the following into the bill:

- Repeals the provision in current law that prohibits a PA from prescribing a psychiatric mental health controlled substance for a minor;
- Provides the following relating to third-party payors:
  - Payment for services within a PA's scope of practice must be made when ordered or performed by a PA if the same service would have been covered if ordered or performed by a physician; and
  - PAs are authorized to bill for and receive direct payment for the services they deliver.
- Repeals the current-law requirement that a licensed PA must notify the DOH within 30 days after starting employment, or after any changes in supervising physician, including the full name, medical license number, specialty, and address of the supervising physician;
- Repeals current law requiring the name, address and telephone number of the supervising physician on PAs prescriptions, but requires PAs' name, address and telephone number on prescriptions;
- Repeals the presumption that the inclusion of the PA prescriber number on a prescription indicates the PA is authorized to prescribe the medicinal drug and the prescription is valid.
- Authorizes PAs to include date of MMI when authenticating medical evaluations for workers' compensation claims;
- Repeals the current-law requirement that PAs must inform patients that they have the right to see the physician before a prescription is prescribed or dispensed by the PA; and
- Authorizes licensed PA to procure medical devices and drugs unless the drug is listed on the negative formulary.

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

APPEARANCE RECORD

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

4-8-21
Meeting Date

894
Bill Number (if applicable)

Topic Physician Assistant Practice

Amendment Barcode (if applicable)

Name Debra Cole

Job Title Physician Assistant

Address 1545 Copperfield Circle
Street
Tallahassee FL 32312
City *State* *Zip*

Phone 850-603-0333

Email debgor@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Academy of Physician Assistants

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4 April 2024
Meeting Date

894
Bill Number (if applicable)

Topic Physician Assistants

Amendment Barcode (if applicable)

Name Diego Echeverri

Job Title Legislative Liaison

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Americans For Prosperity

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

4-8-21
Meeting Date

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

894
Bill Number (if applicable)

Topic Physician Assistant Practice

Amendment Barcode (if applicable)

Name James Zedaker

Job Title Physician Assistant

Address 9503 Boykin Rd.
Street

Phone 850-766-4694

Tallahassee FL 32317
City *State* *Zip*

Email JimZedaker.net

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Academy of Physician Assistants

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

By the Committee on Health Policy; and Senator Diaz

588-02977-21 2021894c1

A bill to be entitled

An act relating to physician assistants; amending ss. 458.347 and 459.022, F.S.; revising legislative intent; defining and redefining terms; deleting a limitation on the number of physician assistants a physician may supervise at one time; deleting a provision prohibiting a requirement that a supervising physician review and cosign charts or medical records prepared by a physician assistant under his or her supervision; deleting a requirement that a physician assistant inform his or her patients that they have the right to see a physician before the physician assistant prescribes or dispenses a prescription; authorizing physician assistants to procure drugs and medical devices; providing an exception; conforming provisions to changes made by the act; revising requirements for a certain formulary; authorizing physician assistants to authenticate documents that may be authenticated by a physician; authorizing physician assistants to supervise medical assistants; authorizing third-party payors to reimburse employers of physician assistants for services rendered; providing requirements for such payment for services; authorizing physician assistants to bill for and receive direct payment for services they deliver; revising provisions relating to approved programs for physician assistants; revising provisions relating to physician assistant licensure requirements; amending ss. 382.008, 394.463, and 401.45, F.S.; conforming

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588-02977-21 2021894c1

provisions relating to certificates of death, certificates for involuntary examinations, and orders not to resuscitate, respectively, to changes made by the act; providing an effective date.

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

Section 1. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 458.347, Florida Statutes, are amended to read:

458.347 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in the field of medicine, to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of physicians or groups of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that he or she can operate efficiently and effectively in the specialty areas in which he or she has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

(h) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of

telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

~~(g) "Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.~~

(c) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(b) This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.

(c) Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(d) A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant ~~and inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and of any change in

prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to paragraph (f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's~~, in addition to the supervising physician's~~ name, address, and telephone number~~, the physician assistant's prescriber number~~. Unless it is a drug or

drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. ~~The inclusion of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.~~

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(f)1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include general anesthetics and radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. ~~The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.~~

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 459, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, a deletion, or a modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the

formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

(g) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 459, or rules adopted under this chapter or chapter 459.

(i) A physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s.

394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.

3. Death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(j) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

(k) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician

assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its successor entity or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization. Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met.~~

~~(c) Any community college with the approval of the State Board of Education may conduct a physician assistant program which shall apply for national accreditation through the American Medical Association's Committee on Allied Health, Education, and Accreditation, or its successor organization, and which may admit unlicensed physicians, as authorized in subsection (7), who are graduates of foreign medical schools listed with the World Health Organization. The unlicensed physician must have been a resident of this state for a minimum~~

~~of 12 months immediately prior to admission to the program. An evaluation of knowledge base by examination shall be required to grant advanced academic credit and to fulfill the necessary requirements to graduate. A minimum of one 16-week semester of supervised clinical and didactic education, which may be completed simultaneously, shall be required before graduation from the program. All other provisions of this section shall remain in effect~~.

(6)~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program ~~specified in subsection (6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course~~

~~description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, who expects to take the first examination administered by the National Commission on Certification of Physician Assistants available for registration after the applicant's graduation, a temporary license. The temporary license shall expire 30 days after receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before employment ~~but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than

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two temporary licenses and may not be licensed as a physician assistant until he or she passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(12) ~~(13)~~ RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

Section 2. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 459.022, Florida Statutes, are amended to read:

459.022 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in the field of medicine, to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of osteopathic physicians or groups of osteopathic physicians by enabling them to delegate health care tasks to qualified~~

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~~assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that she or he can operate efficiently and effectively in the specialty areas in which she or he has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by osteopathic physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

(h) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical

services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

~~(g) "Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.~~

(c) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician~~

~~assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(b) This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.

(c) Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(d) A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary

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created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant ~~and must inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to s. 458.347(4)(f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider that has been approved by the American Academy of Physician Assistants and which is designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

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~~4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's~~, in addition to the supervising physician's~~ name, address, and telephone number~~, the physician assistant's prescriber number~~. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. ~~The inclusion of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.~~

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(f) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(g) A licensed physician assistant may perform services

delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 458, or rules adopted under this chapter or chapter 458.

(h) A physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.

3. Death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(i) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

(j) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same

service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its successor entity or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met~~.

(6)~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician

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

assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current

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

certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program ~~specified in subsection (6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, a temporary license to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice to physician assistant applicants based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before ~~prior to~~ employment~~, but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed, but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until she or he passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(12)~~(13)~~ RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the

application for licensure and notification pursuant to subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

Section 3. Paragraph (a) of subsection (2) and subsections (3) and (5) of section 382.008, Florida Statutes, are amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after

expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent's primary or attending practitioner or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending practitioner or the medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief. As used in this section, the term "primary or attending practitioner" means a physician, physician assistant, or advanced practice registered nurse registered under s. 464.0123 who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department may grant the funeral director an extension of time upon a good and sufficient showing of any of the following conditions:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

(b) If the decedent's primary or attending practitioner or the district medical examiner of the county in which the death occurred or the body was found indicates that he or she will sign and complete the medical certification of cause of death but will not be available until after the 5-day registration deadline, the local registrar may grant an extension of 5 days.

If a further extension is required, the funeral director must provide written justification to the registrar.

(5) A permanent certificate of death or fetal death, containing the cause of death and any other information that was previously unavailable, shall be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or district medical examiner of the county in which the death occurred or the body was found, as appropriate.

Section 4. Paragraph (a) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system

pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that

conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

Section 5. Paragraphs (a) and (c) of subsection (3) of section 401.45, Florida Statutes, are amended to read:

401.45 Denial of emergency treatment; civil liability.—

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician or physician assistant is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department.

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

(c) The department, in consultation with the Department of Elderly Affairs and the Agency for Health Care Administration, shall develop a standardized do-not-resuscitate identification system with devices that signify, when carried or worn, that the possessor is a patient for whom a physician or physician assistant has issued an order not to administer cardiopulmonary resuscitation. The department may charge a reasonable fee to cover the cost of producing and distributing such identification devices. Use of such devices shall be voluntary.

Section 6. This act shall take effect July 1, 2021.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
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	.	

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

Senate Amendment (with title amendment)

Delete lines 104 - 575

and insert:

acts and omissions of the physician assistant. A physician may not supervise more than 10 ~~four~~ currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.


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(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(b) This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.

(c) Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(d) A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician’s practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician’s practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the


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patient that he or she is a physician assistant ~~and inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to paragraph (f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the requirements of this paragraph. The physician assistant~~

~~is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's, in addition to the supervising physician's name, address, and telephone number~~, the physician assistant's prescriber number~~. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. ~~The inclusion of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.~~

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(f)1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include general anesthetics and radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. The formulary must also restrict the prescribing of Schedule II psychiatric mental health controlled substances for children younger than 18 years of age to a 14-day supply, provided the physician assistant is under the supervision of a pediatrician, family practice physician, or psychiatrist.

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed

under this chapter or chapter 459, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, a deletion, or a modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

(g) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician’s patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant’s practice in accordance with his or her education and


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training unless expressly prohibited under this chapter, chapter 459, or rules adopted under this chapter or chapter 459.

(i) Except for a physician certification under s. 381.986, a physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician, except those required for s. 381.986. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.

3. Death certificates.

4. School physical examinations.

5. Medical examinations for workers' compensation claims, except medical examinations required for the evaluation and assignment of the claimant's date of maximum medical improvement as defined in s. 440.02 and for the impairment rating, if any, under s. 440.15.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(j) A physician assistant may supervise medical assistants as defined in this chapter.

(k) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within


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the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its successor entity or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization. Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards~~


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~~shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met.~~

~~(c) Any community college with the approval of the State Board of Education may conduct a physician assistant program which shall apply for national accreditation through the American Medical Association's Committee on Allied Health, Education, and Accreditation, or its successor organization, and which may admit unlicensed physicians, as authorized in subsection (7), who are graduates of foreign medical schools listed with the World Health Organization. The unlicensed physician must have been a resident of this state for a minimum of 12 months immediately prior to admission to the program. An evaluation of knowledge base by examination shall be required to grant advanced academic credit and to fulfill the necessary requirements to graduate. A minimum of one 16-week semester of supervised clinical and didactic education, which may be completed simultaneously, shall be required before graduation from the program. All other provisions of this section shall remain in effect~~.

(6) ~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020,


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has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of


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Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program ~~specified in subsection (6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, who expects to take the first examination administered by the National Commission on Certification of Physician Assistants available for registration after the applicant’s graduation, a temporary license. The temporary


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license shall expire 30 days after receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before employment ~~but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until he or she passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(12) ~~(13)~~ RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of


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them by physicians or groups of physicians.

Section 2. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 459.022, Florida Statutes, are amended to read:

459.022 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in the field of medicine, to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of osteopathic physicians or groups of osteopathic physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that she or he can operate efficiently and effectively in the specialty areas in which she or he has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by osteopathic physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before


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2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

(h) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

~~(g) "Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission~~

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~~on Certification of Physician Assistants.~~

(c)~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. A physician may not supervise more than 10 ~~four~~ currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(b) This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.

(c) Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the


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supervising physician is a staff member in good standing.

(d) A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant ~~and must inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical


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devices and drugs unless the medication is listed on the formulary created pursuant to s. 458.347(4)(f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider that has been approved by the American Academy of Physician Assistants and which is designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's, in addition to the supervising physician's name, address, and telephone number~~, the physician assistant's prescriber number~~. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. ~~The inclusion of the prescriber number creates a presumption that the physician~~

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~~assistant is authorized to prescribe the medicinal drug and the prescription is valid.~~

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(f) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(g) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 458, or rules adopted under this chapter or chapter 458.

(h) Except for a physician certification under s. 381.986, a physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician, except those required for s. 381.986. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.


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3. Death certificates.

4. School physical examinations.

5. Medical examinations for workers' compensation claims, except medical examinations required for the evaluation and assignment of the claimant's date of maximum medical improvement as defined in s. 440.02 and for the impairment rating, if any, under s. 440.15.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(i) A physician assistant may supervise medical assistants as defined in chapter 458.

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

And the title is amended as follows:

Delete lines 4 - 19

and insert:

intent; defining and redefining terms; revising a limitation on the number of physician assistants a physician may supervise at one time; deleting a requirement that a physician assistant inform his or her patients that they have the right to see a physician before the physician assistant prescribes or dispenses a prescription; authorizing physician assistants to procure drugs and medical devices; providing an exception; conforming provisions to changes made by the act; revising requirements for a certain formulary; authorizing physician assistants to authenticate documents that may be authenticated by a

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504 physician; providing exceptions; authorizing

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 900
INTRODUCER:	Senator Rodriguez
SUBJECT:	Child Welfare
DATE:	April 7, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Cox	CF	**Favorable**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.			AP	

I. Summary:

SB 900 makes a number of changes in the laws relating to child welfare that are necessary for the Department of Children and Families (DCF) to be in compliance with new federal requirements that are the result of the expiration of the state's Title IV-E waiver and the upcoming implementation date of the federal Family First Prevention Services Act (FFPSA).

The bill provides a definition for the term "voluntary services" and expands the entities that have access to confidential reports and records in cases of child abuse or neglect to include employees, authorized agents, and contract providers of the Agency for Health Care Administration and the Agency for Persons with Disabilities.

The bill clarifies the Extended Foster Care (EFC) program requirements aligning eligibility with the federal law regarding supervised independent living settings by:

- Specifying that licensed foster homes are the preferred supervised living arrangements for young adults;
- Prohibiting specified living arrangements from being used; and
- Prohibiting involuntary placements for young adults participating in EFC.

The bill also provides that safe houses must care for children who are victims of commercial sexual exploitation in a manner that separates those children who have other needs, but specifies that this provision does not apply to safe foster homes.

The bill increases the capacity of children that can be placed in a licensed foster home without an additional assessment and provides the DCF with the ability to adopt rules to establish requirements for requesting a waiver for over-capacity.

The bill will require the DCF to update the Florida Safe Families Network (FSFN), however, the one-time cost is anticipated to be minimal and may be absorbed by the department within existing resources.

See Section V. Fiscal Impact Statement.

The bill has an effective date of July 1, 2021.

II. Present Situation:

Chapter 39, F.S., Dependency Process - Overview

The Department of Children and Families (DCF) operates the Florida central abuse hotline (hotline), which accepts reports of known or suspected child abuse,[1] abandonment,[2] or neglect, [3] 24 hours a day, seven days a week.[4] Any person who knows or suspects that a child has been abused, abandoned, or neglected must report such knowledge or suspicion to the hotline.[5] A child protective investigation begins if the hotline determines the allegations meet the statutory definition of abuse, abandonment, or neglect.[6] A child protective investigator investigates the situation either immediately or within 24 hours after the report is received, depending on the nature of the allegation.[7]

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[1] Section 39.01(2), F.S., defines "abuse" to mean any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes the birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home. Abuse of a child also includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

[2] *See* s. 39.01(1), F.S., which defines "abandonment", in part, to mean a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. It further defines, "establish or maintain a substantial and positive relationship" to include, but not be limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and the exercise of parental rights and responsibilities. The definition specifically provides that marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child.

[3] Section 39.01(50), F.S., defines "neglect" to mean when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. Circumstances are not to be considered neglect if caused primarily by financial inability unless actual services for relief have been offered to and rejected. Further, a parent or legal custodian legitimately practicing religious beliefs in accordance with a recognized church or religious organization who thereby does not provide specific medical treatment for a child may not, for that reason alone, be considered a negligent parent or legal custodian, unless a court orders the following services to be provided, when the health of the child so requires: medical services from a licensed physician, dentist, optometrist, podiatric physician, or other qualified health care provider; or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization. The definition further provides that neglect of a child includes acts or omissions.

[4] Section 39.201(5), F.S.

[5] Section 39.201(a), F.S.

[6] Section 39.201(2)(a), F.S.

[7] Section 39.201(5), F.S.

If, after conducting an investigation in response to receiving a call to the hotline, the child protective investigator determines that the child is in need of protection and supervision that necessitates removal, the investigator may initiate formal proceedings to remove the child from his or her home. The proceeding, known as a shelter hearing, results in a court determining if probable cause exists to keep a child in shelter[8] status pending further investigation of the circumstances leading to the detention of a child.[9]

When the DCF removes a child from the home, a series of dependency court proceedings must occur before a child may be adjudicated dependent.[10] Within 28 days after a child has been sheltered, the court must hold an arraignment hearing on the petition for dependency.[11] If a parent or legal guardian denies an allegation in the petition, the court must hold an adjudicatory hearing within 30 days.[12]

Subsequent to a child being found dependent, a court must hold a disposition hearing to determine a course of treatment and services and placement of the child under protective supervision.[13] The court must first consider placing the child with relatives.[14] If a child cannot safely remain in the original home and no adult relative is available for temporary legal custody, the child may be placed with an adult willing to care for the child under the protective supervision of the DCF.[15] Placing the child in the temporary legal custody of the DCF invests the DCF with the rights and responsibilities of a legal custodian.[16]

Title IV-E and Title IV-E Waivers

Title IV-E of the Social Security Act[17] is the largest federal funding stream for child welfare activities. The funding stream supports foster care, adoption assistance, and guardianship assistance programs. States receive a level of reimbursement from the federal government for eligible claims. Title IV-E also includes the Chafee Foster Care Independence Program, a capped entitlement for which states are entitled to reimbursement for claims it submits to the federal government, up to a certain level, related to preparing children in out-of-home care for self-sufficiency when they transition out.[18]

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[8] Section 39.01(78), F.S., defines "shelter" to mean a placement with a relative or a nonrelative, or in a licensed home or facility, for the temporary care of a child who is alleged to be or who has been found to be dependent, pending court disposition before or after adjudication.
[9] Section 39.01(79), F.S.
[10] *See* s. 39.01(15), F.S., for the definition of "child who is found to be dependent".
[11] The purpose of an arraignment hearing is for a parent to admit, deny, or consent to findings of dependency that are alleged in the petition for dependency. If any party has requested a demand for early filing, the court must hold the arraignment hearing within 7 days after the date of filing of the petition. Section 39.506(1), F.S.
[12] Section 39.506(1), F.S.
[13] Section 39.521(1), F.S.
[14] Section 39.507(7)(c), F.S.
[15] Section 39.521(3)(c), F.S.
[16] Section 39.521(3)(d), F.S.
[17] 42 U.S.C. ss. 671-679b.
[18] Child Trends, *A Primer on Title IV-E Funding for Child Welfare, a*vailable at https://www.childtrends.org/wp-content/uploads/2016/01/2016-04TitleIV-EPrimer.pdf (last visited March 8, 2021).

To be eligible for the Title IV-E Foster Care Program, the vehicle through which states receive Title IV-E funds for children in foster care, children must:

- Be in out-of-home placements;
- Have been removed from families that are considered "needy";
- Have entered care through a judicial determination or voluntary placement; and
- Be in licensed or approved foster care placements.[19]

Title IV-E waivers were first available as an option to states in 1994, when Section 1130 of the Social Security Act gave the U.S. Department of Health and Human Services the authority to approve demonstration projects for which states can waive certain requirements of Title IV-E. These were designed to provide states with opportunities and the flexibility to use federal funds to test innovative approaches to child welfare service delivery and financing.[20]

The DCF participated in the Title IV-E Waiver Demonstration for approximately 13 years. The Florida Title IV-E Waiver Demonstration Project was implemented statewide on October 1, 2006. The purpose of the waiver project was to determine whether increased spending flexibility of Title IV-E funding would support changes in the state's service delivery system, maintain cost neutrality to the federal government, and most importantly, maintain child safety as well as improving permanency and well-being outcomes for children and their families being served within Florida's child welfare system. In exchange, Florida agreed to a capped allocation with annual automatic increases plus triggers to adjust the allocation if actual levels significantly exceeded estimates.[21]

The need for DCF to claim Title IV-E funding returned to traditional program requirements due to the expiration of the state's waiver demonstration on September 30, 2019. In order to minimize the potential gap in needed funding, the DCF began to implement a plan it referred to as Path Forward in the 2018-19 fiscal year. The Path Forward plan encompassed four initiatives including: Title IV-E Extended Foster Care, Title IV-E Guardianship Assistance Program (GAP), Foster Care Candidacy, and Title IV-E Eligibility Rate Improvements. Currently, the DCF has implemented all of these initiatives and is monitoring performance closely to ensure the projected goals are met. In addition, the DCF is attempting to ensure that Florida statutes align with federal requirements to enable the DCF to maximize federal IV-E claiming.[22]

Family First Prevention Services Act

The federal Family First Prevention Services Act (FFPSA), included in the 2018 Bipartisan Budget Act,[23] focuses on evidence-based services to prevent children from entering foster care;

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[19] *Id*.
[20] Child Welfare Information Gateway, *Child Welfare Demonstration Waivers*, available at https://www.childwelfare.gov/topics/management/reform/waivers/ (last visited March 8, 2021).
[21] Armstrong, M.I., Vargo, A.C., Jordan, N., Sharrock, P., Sowell, C, Yampolskaya, S., Kip. S. (2009). *Evaluation brief on the status, activities and findings related to Florida's IV-E waiver demonstration project: Two years post-implementation.* University of South Florida, Louis de la Parte Florida Mental Health Institute, available at https://www.myflfamilies.com/general-information/publications-forms/docs/APSR/S10-008463_Title%20IV-E%20Brief%202%20January2010.pdf (last visited March 8, 2021).
[22] The DCF, *2021 Agency Legislative Bill Analysis, SB 900*, January 24, 2021, p. 2 (on file with the Senate Committee on Children, Families and Elder Affairs) (hereinafter cited as "The DCF SB 900 Agency Analysis").
[23] H.R. 1862 of 2018. Pub.L. 115-123

limits reimbursement for congregate (group home) care; and makes changes affecting adoption subsidies, reunification, and extended foster care supports. The FFPSA reformed the federal child welfare funding streams. Unlike the previous Title IV-E provisions which primarily funded out-of-home care for families with very low incomes, the FFPSA gives states the ability to earn federal Title IV-E matching funds in support of certain prevention services provided on a time-limited basis that avoid an out-of-home placement for children without regard to family income. In providing for children and their families meeting eligibility requirements, the FFPSA provides for the reimbursement of specific federally approved, evidence-based services that address mental health, substance abuse, family counseling, and parent skills training. The FFPSA also limits federal funding for group homes placements.[24]

The Title IV- E Prevention Services Clearinghouse was established by the U.S. Department of Health and Human Services Administration for Children and Families (ACF) to conduct an objective and transparent review of research on programs and services intended to provide enhanced support to children and families and prevent foster care placements. The Prevention Services Clearinghouse, developed in accordance with the FFPSA and codified in Title IV-E of the Social Security Act, rates programs and services as well-supported, supported, promising, or does not currently meet criteria.[25]

Congress made the FFPSA effective October 1, 2018, but gave states the opportunity to delay implementation of select provisions of the law.[26] Florida received approval to delay the implementation of the FFPSA until October 1, 2021.[27]

Voluntary Services

Currently, there is no definition for the term "voluntary services" in Florida law, even though it's used either specifically or conceptually in a number of places in ch. 39, F.S., including:

- **Section 39.501(3)(d)1., F.S.**, relating to a petition for dependency, provides whether a parent or legal custodian named in the petition has previously unsuccessfully participated in voluntary services offered by the DCF.
- **Section 39.823, F.S.**, relating to guardian advocates for drug dependent newborns, provides because of the parents' continued dependence upon drugs, the parents may temporarily leave their child with a relative or other adult or may have agreed to voluntary family services under s. 39.301(14), F.S.

[24] The DCF, *The Florida Center for Child Welfare FFPSA Updates*, available at http://centerforchildwelfare.fmhi.usf.edu/FFPSA.shtmll; *see also* the National Conference of State Legislatures (NCSL), *Family First Prevention Services Act*, available at https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx (all sites last visited March 14, 2021).
[25] *See* the U.S. Department of Health and Human Services, Office of Planning, Research, and Evaluation, *Title IV-E Prevention Services Clearinghouse, 2018 – 2023*, available at https://www.acf.hhs.gov/opre/project/title-iv-e-prevention-services-clearinghouse-2018-2023 (last visited March 15, 2021).
[26] The NCSL, *Family First Prevention Services Act*, available at https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx (last visited March 15, 2021).
[27] The DCF SB 900 Agency Analysis, p. 4.

Out-of-Home Placement Settings

When it becomes necessary for the DCF to remove a child from the home, efforts must be made to place the child in the least restrictive placement.[28] The community-based care lead agency (lead agency) is required to complete a comprehensive placement assessment to determine the appropriate level of care.[29] Relatives and non-relatives are considered the least restrictive level of care but should a suitable relative or non-relative not be available, a foster home would be the next appropriate level of care and then a group home setting.[30]

A safe house is one of the FFPSA placement settings currently licensed and certified by the DCF.[31] The DCF currently allows for the placement of victims of, or at risk of, human trafficking to be placed in the same safe house setting with any other population, as long as the children who have not experienced commercial sexual exploitation do not interact with victims of trafficking.[32] There are ten group homes that wish to transition to a safe house. FFPSA will require that safe houses strictly serve victims of, or at risk of, human trafficking. Current laws create a barrier to the DCF's ability to claim Title IV-E as a safe house is permitted to serve a victim of, or at risk of, human trafficking in the same setting with children of any population.[33]

Parenting Partnerships for Children in Out-of-Home Care

Current law requires all direct caregivers employed by residential group homes to meet the same education, training, and background and other screening requirements as foster parents. The current law creates a barrier to group home providers that are gathering criminal records in a timely manner, thus affecting Title IV-E payments.

Foster Home Capacity

Section 409.175(3), F.S., requires an over-capacity waiver assessment when the number of children in a foster home exceeds five, including the foster parents own children, while the federal language allows up to six children to be placed in a foster home, excluding the foster parents own children, before being considered over-capacity.[34] In addition, current language allows for the ability to assess and grant an over-capacity waiver for any reason, while federal language only allows for over-capacity when:

- A parenting youth in foster care needs to remain with their child;
- Siblings need to remain together;
- A child with an established meaningful relationship with the family needs to remain with the family; or
- A family with special training or skills needs to provide care to a child who has a severe disability.[35]

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[28] Section 39.523(1)(a), F.S.
[29] The DCF, *Community-Based Care*, available at https://www.myflfamilies.com/service-programs/community-basedcare/overview.shtml (last visited March 15, 2021).
[30] Section 39.523(2), F.S.
[31] Section 409.1678(1)(b), F.S., defines the term "safe house" as a group residential placement certified by the DCF to care for sexually exploited.
[32] Section 409.1678(2)(b), F.S.
[33] The DCF SB 900 Agency Analysis, p. 6.
[34] 42 U.S.C. s. 672(c)(B).
[35] *Id.*

Continuing Care for Young Adults – Extended Foster Care (EFC)

Section 39.6251, F.S., provides conditions pertaining to supervised living environments requiring an independent living setting, giving some flexibility based on lead agency assessment and approval. The statute does not define independent living for the purposes of supervised living environments, but requires that the young adult reside in a supervised living environment that is approved by the DCF or lead agency. The young adult must live independently, but in an environment in which he or she is provided supervision, case management, and supportive services by the DCF or lead agency. Such an environment must offer developmentally appropriate freedom and responsibility to prepare the youth for adulthood.[36]

Such a supervised living arrangement may include a licensed foster home, licensed group home, college dormitory, shared housing, apartment, or another housing arrangement if the arrangement is approved by the lead agency and is acceptable to the young adult. A young adult may also continue to reside with the same licensed foster family or group care provider with whom he or she was residing at the time the youth reached the age of 18.[37]

In addition, current law does not prohibit involuntary placements nor does it exclude settings in which delinquent youth or young adults are detained or incarcerated.[38]

Confidentiality of Reports and Records

Currently, in order to protect the rights of the child and the child's parents or other persons responsible for the child's welfare, s. 39.202, F.S., provides that all records held by the DCF concerning reports of child abandonment, abuse, or neglect, including reports made to the central abuse hotline and all records generated as a result of such reports, are confidential and exempt from the provisions of s. 119.07(1), F.S., and must not be disclosed except as specifically authorized by chapter 39, F.S. The exemption also applies to information in the possession of those entities granted access under this section.[39]

Information made confidential and exempt under s. 39.202, F.S., may only be released in a specified manner and to specified individuals.[40] Exceptions to this are provided for cases involving a child who is missing.[41] Current law does not provide the Agency for Health Care Administration (AHCA) and the Agency for Person with Disability (APD) the capability to complete child abuse and neglect record checks for their employees who work in direct contact with children placed by the DCF in facilities licensed by the AHCA.[42]

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[36] Section 39.6251(4)(a), F.S.
[37] *Id*.
[38] Section 39.6251, F.S.
[39] Section 39.202(1). F.S. When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." Custodians of records designated as "exempt" are not prohibited from disclosing the record; rather, the exemption means that the custodian cannot be compelled to disclose the record. Custodians of records designated as "confidential and exempt" may not disclose the record except under circumstances specifically defined by the Legislature.
[40] Section 39.202(2), F.S.
[41] *See* s. 39.202(4), F.S.
[42] Section 39.202(2), F.S.

Protective Investigations of Institutional Child Abuse, Abandonment, or Neglect

Current law allows that when a person who is employed as a caregiver in a licensed residential group home and is named in any capacity in three or more reports of institutional child abuse, abandonment, or neglect within a five-year period, the DCF may review all reports for the purposes of the employment screening requirements in s. 409.145(2)(e), F.S.[43]

Section 409.175(2)(m), F.S., relating to the licensure of family foster homes, residential child-caring agencies, and child-placing agencies, provides that the term "screening" means the act of assessing the background of personnel of level II through level V family foster homes and includes, but is not limited to, employment history checks as provided in chapter 435, using level 2 screening standards.

III. Effect of Proposed Changes:

Title IV-E Waiver

Confidentiality of Reports and Records

The bill amends s. 39.202, F.S., related to the confidentiality of reports and records pertaining to child abuse, neglect, and abandonment, allowing the Agency for Health Care Administration (AHCA) and the Agency for Persons with Disabilities (APD) to review child abuse and neglect reports for employees who work in facilities licensed under chs. 393, 394, and 409, F.S., to meet federal requirements for children under the care and supervision of the DCF who are placed in these facilities.[44] The changes will allow the agencies to ensure children remain safe during their placement through receiving reports related to an employee that indicate safety concerns for the children in such facilities.

When an employee is deemed unsafe and remains in a caregiver role, payments for children placed in these facilities will not be federally reimbursable through Title IV-E. The inability to claim federal funding will result in expending more state general revenue funds on these group home placements.

Screenings for Employees of Group Homes Parenting for Children in Out-of-Home Care

The bill amends s. 409.1415(2)(c), F.S., relating to group home employee requirements, removing specific references to background screening and other screening requirements and maintaining the requirement to have the same education and training as licensed foster care placements. The background screening required by the group home employee is maintained as level 2 screening as required in s. 39.0138, F.S., and ch. 435, F.S. This will allow the DCF flexibility to work closely with law enforcement and other background screening units to ensure all checks are completed accurately to avoid costly penalties.

[43] Section 39.302(7)(b), F.S.

[44] Facilities licensed under ch. 393, F.S., care for individuals who have a developmental disability; facilities licensed under ch. 394, F.S., provide care for individuals with mental health issues; and facilities licensed under ch. 409, F.S., provide care for children who are in out-of-home care through the child welfare system.

Protective Investigations for Institutional Abuse

The bill amends s. 39.302(7)(b), F.S., to codify current practice and align the changes in s. 409.1415(2)(c), F.S., to the federal requirements in the FFPSA, allowing the DCF the opportunity to claim federal Title IV-E funds for children placed in facilities licensed by either AHCA or APD.[45]

Continuing Care for Young Adults – Extended Foster Care

The bill amends s. 39.6251, F.S., clarifying that young adults participating in EFC are to reside in *voluntary*, supervised independent living environments. The bill specifies that a supervised living arrangement cannot be a detention facility, forestry camp, training school, or other facility operated primarily for the detention of delinquent children.[46] The bill also provides that an involuntary placement is only authorized if a court-appointed guardian has placed the young adult in such placement.

Family First Prevention Services Act

Voluntary Services

The bill amends s. 39.01, F.S., creating a new definition for the term "voluntary services" to mean social services and other preventive and rehabilitative services provided to the parent or legal custodian of the child or directly to the child, or services provided on behalf of the child, when a parent or legal custodian requests or voluntarily agrees to receive assistance. This new definition will align with federal language that says services can be provided to the parent or legal custodian of the child, and to the child or on behalf of the child.[47]

The new definition will give the DCF the opportunity to claim Title IV-E federal funds for evidence-based prevention services that have been approved through the Federal Clearing House as promising, supported, and well-supported. The amount of increased claiming is currently indeterminate as there is no way to determine how many prevention services statewide will meet the requirements of the Clearinghouse.[48]

Out-of-Home Placement Settings

The bill amends s. 409.1678(2), F.S., to exempt safe foster homes and restrict safe houses from serving victims of commercial sexual exploitation. The new language will restrict placement of populations who are not victims of commercial sexual exploitation from being placed in a safe house setting. This will align with the FFPSA requirements and the DCF's ability to claim Title IV-E federal funds for safe house settings.[49]

Foster Home Capacity

The bill amends s. 409.175, F.S., increasing the capacity of children that can be placed in a licensed foster home without the need for an additional assessment from five children, including

[45] 42 U.S.C. s. 671(a)(20).
[46] Section 39.6251(4), F.S.
[47] 42 U.S.C. ss. 475(13), 471(e), and 474(a)(6).
[48] The DCF SB 900 Agency Analysis, p. 9.
[49] 42 U.S.C. s. 472(k)(2).

the family's own children, to six children, not including the family's own children. In addition, the increase in capacity enables the DCF to adopt rules for approving over-capacity assessments that align with Title IV-E requirements.

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:

None.

C. Government Sector Impact:

The DCF estimates it will cost $115,600 for one-time technology updates to implement provisions in the bill.[50] However, it is anticipated that these expenditures can be absorbed by the DCF using existing department resources.

VI. Technical Deficiencies:

None.

[50] The DCF SB 900 Agency Analysis, p. 12-13.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends ss. 39.01, 39.202, 39.302, 39.6251, 409.1415, 409.1678, and 409.175 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.

The Florida Senate

Committee Agenda Request

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

Subject: Committee Agenda Request

Date: March 22, 2021

I respectfully request that **Senate Bill #900**, relating to Child Welfare, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 39

File signed original with committee office

S-020 (03/2004)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

04/08/2021
Meeting Date

SB 900
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 900 - Child Welfare

Name Michael Wickersheim

Job Title Director of Legislative Affairs

Address 1417 Winewood Blvd.
Street

Phone (850) 488-9410

Tallahassee FL 32399
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Department of Children and Families

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

By Senator Rodriguez

39-01078-21 2021900__

A bill to be entitled

An act relating to child welfare; amending s. 39.01, F.S.; defining the term "voluntary services"; amending s. 39.202, F.S.; expanding the list of entities that have access to child abuse records; amending s. 39.302, F.S.; revising the authority of the Department of Children and Families to review reports for the purpose of employment screening; amending s. 39.6251, F.S.; providing that licensed foster homes are the preferred supervised living arrangements for young adults; prohibiting supervised living arrangements from including specified facilities; prohibiting young adults from being involuntarily placed in any setting unless such placement is through a court-appointed guardian; amending s. 409.1415, F.S.; revising requirements for certain employees of residential group homes; amending s. 409.1678, F.S.; revising certification requirements for safe foster homes; amending s. 409.175, F.S.; requiring assessments to be completed if the total number of children in a family foster home will exceed six, excluding the family's own children, before placement of a child in a family foster home; requiring the department to adopt rules to establish eligibility criteria for requesting a waiver for such assessments and criteria to approve such waivers; providing an effective date.

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

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

39-01078-21 2021900__

Section 1. Subsection (88) is added to section 39.01, Florida Statutes, to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(88) "Voluntary services" means social services and other preventive and rehabilitative services provided to the parent or legal custodian of the child or directly to the child, or services provided on behalf of the child, when a parent or legal custodian requests or voluntarily agrees to assistance.

Section 2. Paragraphs (a) and (h) of subsection (2) of section 39.202, Florida Statutes, are amended to read:

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

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

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

1. Child or adult protective investigations;

2. Ongoing child or adult protective services;

3. Early intervention and prevention services;

4. Healthy Start services;

5. Licensure or approval of adoptive homes, foster homes, child care facilities, facilities licensed under chapters 393

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and 394 ~~chapter 393~~, family day care homes, providers who receive school readiness funding under part VI of chapter 1002, or other homes used to provide for the care and welfare of children;

6. Employment screening for caregivers in residential group homes and facilities licensed under chapters 393, 394, and 409; or

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

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

(h) Any appropriate official of the department, the Agency for Health Care Administration, or the Agency for Persons with Disabilities who is responsible for:

1. Administration or supervision of the department's program for the prevention, investigation, or treatment of child abuse, abandonment, or neglect, or abuse, neglect, or exploitation of a vulnerable adult, when carrying out his or her official function;

2. Taking appropriate administrative action concerning an employee of the department or the agency who is alleged to have perpetrated child abuse, abandonment, or neglect, or abuse, neglect, or exploitation of a vulnerable adult; or

3. Employing and continuing employment of personnel of the department or the agency.

Section 3. Paragraph (b) of subsection (7) of section

39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed under s. 409.175 and is named in any capacity in three or more reports within a 5-year period, the department may review all reports for the purposes of the employment screening required under s. 409.175(2)(m) ~~s. 409.1415(2)(c)~~.

Section 4. Subsection (4) of section 39.6251, Florida Statutes, is amended to read:

39.6251 Continuing care for young adults.—

(4)(a) The young adult must reside in a supervised living environment that is approved by the department or a community-based care lead agency. The young adult shall live independently, but in an environment in which he or she is provided supervision, case management, and supportive services by the department or lead agency. Such an environment must offer developmentally appropriate freedom and responsibility to prepare the young adult for adulthood.

1. For the purposes of this subsection:~~,~~

a. A supervised living arrangement may include a licensed foster home, licensed group home, college dormitory, shared housing, apartment, or another housing arrangement if the arrangement is approved by the community-based care lead agency and is acceptable to the young adult; however, a licensed foster home is the preferred arrangement.

b. A supervised living arrangement may not include a detention facility, a forestry camp, a training school, or any other facility operated primarily for the detention of children who are determined to be delinquent.

2. A young adult may continue to reside with the same licensed foster family or group care provider with whom he or she was residing at the time he or she reached the age of 18 years. A young adult may not reside in any setting in which the young adult is involuntarily placed, unless the placement is through a court-appointed guardian.

(b) Before approving the residential setting in which the young adult will voluntarily live, the department or community-based care lead agency must ensure that:

1. The young adult will be provided with a level of supervision consistent with his or her individual education, health care needs, permanency plan, and independent living goals as assessed by the department or lead agency with input from the young adult. Twenty-four hour onsite supervision is not required; however, 24-hour crisis intervention and support must be available.

2. The young adult will live in an independent living environment that offers, at a minimum, life skills instruction,

counseling, educational support, employment preparation and placement, and development of support networks. The determination of the type and duration of services shall be based on the young adult's assessed needs, interests, and input and must be consistent with the goals set in the young adult's case plan.

Section 5. Paragraph (c) of subsection (2) of section 409.1415, Florida Statutes, is amended to read:

409.1415 Parenting partnerships for children in out-of-home care.—

(2) PARENTING PARTNERSHIPS.—

(c) An employee of a residential group home must meet the background screening requirements under s. 39.0138 and the level 2 screening standards for screening under chapter 435. An employee of a residential group home who works directly with a child as a caregiver must meet, at a minimum, the same education~~,~~ and training~~, background, and other screening~~ requirements as caregivers in family foster homes licensed as level II under s. 409.175(5).

Section 6. Paragraph (c) of subsection (2) of section 409.1678 is amended to read:

409.1678 Specialized residential options for children who are victims of commercial sexual exploitation.—

(2) CERTIFICATION OF SAFE HOUSES AND SAFE FOSTER HOMES.—

(c) To be certified, a safe house must hold a license as a residential child-caring agency, as defined in s. 409.175, and a safe foster home must hold a license as a family foster home, as defined in s. 409.175. A safe house or safe foster home must also:

1. Use strength-based and trauma-informed approaches to care, to the extent possible and appropriate.

2. Serve exclusively one sex.

3. Group child victims of commercial sexual exploitation by age or maturity level.

4. Care for child victims of commercial sexual exploitation in a manner that separates those children from children with other needs; however, this subparagraph does not apply to safe foster homes. ~~Safe houses and safe foster homes may care for other populations if the children who have not experienced commercial sexual exploitation do not interact with children who have experienced commercial sexual exploitation.~~

5. Have awake staff members on duty 24 hours a day, if a safe house.

6. Provide appropriate security through facility design, hardware, technology, staffing, and siting, including, but not limited to, external video monitoring or door exit alarms, a high staff-to-client ratio, or being situated in a remote location that is isolated from major transportation centers and common trafficking areas.

7. Meet other criteria established by department rule, which may include, but are not limited to, personnel qualifications, staffing ratios, and types of services offered.

Section 7. Subsection (3) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(3)(a) The total number of children placed in each family

foster home shall be based on the recommendation of the department, or the community-based care lead agency where one is providing foster care and related services, based on the needs of each child in care, the ability of the foster family to meet the individual needs of each child, including any adoptive or biological children or young adults remaining in foster care living in the home, the amount of safe physical plant space, the ratio of active and appropriate adult supervision, and the background, experience, and skill of the family foster parents.

(b) If the total number of children in a family foster home will exceed six, excluding ~~five, including~~ the family's own children, an assessment of each child to be placed in the home must be completed by a family services counselor and approved in writing by the counselor's supervisor prior to placement of any additional children in the home, except that, if the placement involves a child whose sibling is already in the home or a child who has been in placement in the home previously, the assessment must be completed within 72 hours after placement. The assessment must assess and document the mental, physical, and psychosocial needs of the child and recommend the maximum number of children in a family foster home that will allow the child's needs to be met.

(c) For any licensed family foster home, the appropriateness of the number of children in the home must be reassessed annually as part of the relicensure process. For a home with more than six ~~five~~ children, if it is determined by the licensure study at the time of relicensure that the total number of children in the home is appropriate and that there have been no substantive licensure violations and no indications

of child maltreatment or child-on-child sexual abuse within the past 12 months, the relicensure of the home may ~~shall~~ not be denied based on the total number of children in the home.

(d) The department shall adopt rules to establish eligibility criteria for requesting a waiver for assessments required under this subsection and criteria to approve such waivers.

Section 8. This act shall take effect July 1, 2021.

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	PCS/CS/SB 1142 (337150)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Rodrigues
SUBJECT:	Prohibited Acts by Health Care Practitioners
DATE:	April 12, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Fav/CS**
2.	Howard	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1142 amends s. 456.072(1)(a), Florida Statutes, that provides grounds for discipline applicable to all licensed health care practitioners, to:

- Add the making of misleading, deceptive, or fraudulent representations related to a practitioner's specialty designation as grounds for discipline.
- Provide that the term "anesthesiologist" may be used only by a practitioner licensed under chapters 458 or 459, Florida Statutes, or licensed as a dentist under chapter 466, Florida Statutes.
- Provide that the term "dermatologist" may be used only by a practitioner licensed under chapters 458 or 459, Florida Statutes.

The bill requires that when the Department of Health (department) finds that a health care practitioner has violated section 456.072(1)(a), Florida Statutes pertaining to a specialty designation, as amended by the bill, the department must issue an emergency cease and desist order and take disciplinary action if the practitioner fails to comply with the order.

The bill also amends section 456.072(1)(t), Florida Statutes, to provide disciplinary action based on a licensed health care practitioner's failure to identify his or her specialty designation and requiring the department, not a practitioner regulatory board, to enforce section 456.072(1)(t), Florida Statutes.

The department may experience a workload increase associated with additional complaints and nonrecurring costs associated with rule-making; however, these costs can be absorbed within existing resources.

The bill takes effect upon becoming a law.

II. Present Situation:

The Department of Health

The Legislature created the Department of Health (department) to protect and promote the health of all residents and visitors in the state.[1] The department is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[2] and professions within the department.[3] Health care practitioners licensed by the department include the following:

- Acupuncturist;[4]
- Allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants;[5]
- Osteopathic physicians, physician assistants, and anesthesiologist assistants;[6]
- Chiropractic physicians and physician assistants;[7]
- Podiatric physicians;[8]
- Naturopathic physicians;[9]
- Optometrists;[10]
- Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants;[11]
- Pharmacists, pharmacy interns, and pharmacy technicians;[12]
- Dentists, dental hygienists, and dental laboratories;[13]
- Midwives;[14]
- Speech and language pathologists;[15]
- Audiologists;[16]

[1] Section 20.43, F.S.
[2] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the department or, in some cases, within the MQA.
[3] Section 20.43, F.S.
[4] Chapter 457, F.S.
[5] Chapter 458, F.S.
[6] Chapter 459, F.S.
[7] Chapter 460, F.S.
[8] Chapter 461, F.S.
[9] Chapter 462, F.S.
[10] Chapter 463, F.S.
[11] Chapter 464, F.S.
[12] Chapter 465, F.S.
[13] Chapter 466, F.S.
[14] Chapter 467, F.S.
[15] Part I, Chapter 468, F.S.
[16] *Id.*

- Occupational therapists and occupational therapy assistants;[17]
- Respiratory therapists;[18]
- Dieticians and nutritionists;[19]
- Athletic trainers;[20]
- Orthotists, prosthetists, and pedorthists;[21]
- Electrologists;[22]
- Massage therapists;[23]
- Clinical laboratory personnel;[24]
- Medical physicists;[25]
- Opticians;[26]
- Hearing aid specialists;[27]
- Physical therapists;[28]
- Psychologists and school psychologists;[29] and
- Clinical social workers, mental health counselors, and marriage and family therapists.[30]

For each profession under the jurisdiction of the department, the department appoints the board executive director, subject to board approval.[31] The duties of the boards do not include the enlargement, modification, or contravention of the scope of practice of a profession regulated by each board, unless expressly and specifically granted by statute, but the boards may take disciplinary action against a licensee or issue a declaratory statement.[32] Each board member is appointed by the Governor and accountable to the Governor for the proper performance of his or her duties as a member of a board.[33]

Board of Medicine (BOM)

The BOM was established to ensure that every medical doctor practicing in this state meets minimum requirements for safe practice. The practice of medicine is a privilege granted by the state. The BOM, through efficient and dedicated organization, is directed to license, monitor, discipline, educate, and, when appropriate, rehabilitate physicians and other practitioners to assure their fitness and competence.[34]

[17] Part III, Chapter 468, F.S.
[18] Part V, Chapter 468, F.S.
[19] Part X, Chapter 468, F.S.
[20] Part XIII, Chapter 468, F.S.
[21] Part XIV, Chapter 468, F.S.
[22] Chapter 478, F.S.
[23] Chapter 480, F.S.
[24] Part II, Chapter 483, F.S.
[25] Part III, Chapter 483, F.S.
[26] Part I, Chapter 484, F.S.
[27] Part II, Chapter 484, F.S.
[28] Chapter 486, F.S.
[29] Chapter 490, F.S.
[30] Chapter 491, F.S.
[31] Section 456.004, F.S.
[32] Section 456.003(6), F.S.
[33] Section 456.008, F.S.
[34] The Department of Health, *Board of Medicine*, *available at* https://flboardofmedicine.gov/ (last visited Mar. 9, 2021).

Board of Osteopathic Medicine (BOOM)

The BOOM was legislatively established to ensure that every osteopathic physician practicing in this state meets minimum requirements for safe practice. The BOOM is responsible for licensing, monitoring, disciplining, and educating osteopathic physicians to assure competency and safety to practice in Florida.[35]

Board of Dentistry (BOD)

The BOD was established to ensure that every dentist and dental hygienist practicing in this state meets minimum requirements for safe practice. The practice of the profession is a privilege granted by the state. The BOD is responsible for licensure, monitoring and ensuring the safe practice of dentists and dental hygienists.[36]

Board of Nursing (BON)

The BON licenses, monitors, disciplines, educates, and, when appropriate, rehabilitates its licensees to assure their fitness and competence in providing health care services for the people of Florida. The sole legislative purpose in enacting the Nurse Practice Act is to ensure that every nurse practicing in Florida meets minimum requirements for safe practice. It is the intent of the Legislature that nurses who fall below minimum competency or who otherwise present a danger to the public must be prohibited from practicing in Florida.[37]

Section 464.015, F.S., clearly specifies the permissible nursing titles a person may use that holds a valid nursing license in this state, or a multistate license, as follows:

- Licensed Practical Nurse – L.P.N.;
- Registered Nurse – R.N.;
- Clinical Nurse Specialist – C.N.S.;
- Certified Registered Nurse Anesthetist – C.R.N.A. or nurse anesthetist;
- Certified Nurse Midwife – C.N.M. or nurse midwife; and
- Advanced Practice Registered Nurse – A.P.R.N.

A person may not practice or advertise as a registered nurse, licensed practical nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, certified nurse practitioner, or advanced practice registered nurse, or use the abbreviation R.N., L.P.N., C.N.S., C.R.N.A., C.N.M., C.N.P., or A.P.R.N., or take any other action that would lead the public to believe that person was authorized by law to practice professional nursing, if the person is not licensed as such, and to do so is a first degree misdemeanor.[38]

[35] The Department of Health, *Board of Osteopathic Medicine*, *available at* https://floridasosteopathicmedicine.gov/ (last visited Mar. 9, 2021).
[36] The Department of Health, *Board of Dentistry*, *available at* https://floridasdentistry.gov/ (last visited Mar. 9, 2021).
[37] The Department of Health, *Board of Nursing*, *available at* https://floridasnursing.gov/ (last visited Mar. 9, 2021).
[38] Section 464.015, F.S.

Disciplinary Proceedings under Chapter 456, F.S.

Section 456.072, F.S., sets out grounds for discipline and due process that are applicable to all licensed health care practitioners, in addition to the grounds set out in each practice act, and includes:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession;
- Intentionally violating any board or the department rule;
- Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, and failing to report the violation within 30 days, including a crime:
  - Relating to practice, or ability to practice, a profession;
  - Relating to Medicaid fraud; and
  - Relating to health care fraud.
- Using a Class III or Class IV laser device without having complied with registration rules for the devices;
- Failing to comply with the continuing education (CE) requirements for:
  - HIV/AIDS; and
  - Domestic violence.
- Having a license revoked, suspended, or acted against, including denial, or by relinquishment, stipulation, consent order, or settlement, in any jurisdiction;
- Having been found civilly liable for knowingly filing a false report or complaint with the department against another licensee;
- Attempting to obtain, or renewing a license by bribery, fraudulent misrepresentation, or through the department error;
- Failing to report to the department any person who the licensee knows is in violation of ch. 456, F.S., or the chapter and rules regulating the practitioner;
- Aiding, assisting, procuring, employing, or advising a person to practice a profession without a license;
- Failing to perform a statutory or legal obligation;
- Knowingly making or filing a false report;
- Making deceptive, untrue, or fraudulent representations in the licensee's practice;
- Exercising undue influence on the patient for financial gain;
- Knowingly practicing beyond his or her scope of practice or is not competent to perform;
- Delegating professional responsibilities to person licensee knows is not qualified to perform;
- Violating a lawful order of the department or a board, or failing to comply with a lawfully issued subpoena of the department;
- Improperly interfering with an investigation, inspection, or disciplinary proceeding;
- Failing to identify through written notice, that may include the wearing of a name tag, or orally to a patient, the type of license under which the practitioner is practicing, including in advertisements;[39]
- Failing to provide patients information about their rights and how to file a complaint;
- Engaging or attempting to engage in sexual misconduct;

[39] This ground does not apply to a practitioner while the practitioner is providing services in a facility licensed under chs. 394, 395, 400, or 429, F.S.

- Failing to comply with the requirements for profiling and credentialing;
- Failing to report within 30 days that the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction;
- Using information from police reports, newspapers, other publications, or through a radio or television, for commercial purposes or solicitation;
- Being unable to practice with reasonable skill and safety because of illness or use of alcohol, drugs, narcotics, chemicals, or as a result of a mental or physical condition;
- Testing positive for any illegal drug on any pre-employment or employer-ordered screening when the practitioner does not have a prescription;
- Performing or attempting to perform health care services on the wrong patient, wrong-site, or an unauthorized procedure or medically unnecessary procedure;
- Leaving a foreign body in a patient;
- Violating any provision of the applicable practice act or rules;
- Intentionally submitting a Personal Injury Protection (PIP) claim, that has been "upcoded;"
- Intentionally submitting a PIP claim for services not rendered;
- Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances that demonstrates a lack of reasonable skill or safety to patients;
- Being terminated from an impaired practitioner program for failing to comply;
- Failure to comply with controlled substance prescribing requirements;
- Intentionally entering any information concerning firearm ownership into the patient's medical record; and
- Willfully failing to authorize emergency care or services with such frequency as to indicate a general business practice.

The department, on behalf of the boards, investigates any complaint that is filed against a health care practitioner if the complaint is:[40]

- In writing;
- Signed by the complainant;[41] and
- Legally sufficient.

A complaint is legally sufficient if it contains allegations of ultimate facts that, if true, show that a regulated practitioner has violated:

- Chapter 456, F.S.;
- His or her practice act; or
- A rule of his or her board or the department.[42]

The Consumer Services Unit receives the complaints and refers them to the closest Investigative Services Unit (ISU) office. The ISU investigates complaints against health care practitioners. Complaints that present an immediate threat to public safety are given priority; however, all complaints are investigated as timely as possible. When the complaint is assigned to an

[40] Section 456.073(1), F.S.
[41] *Id.* The department may also investigate an anonymous complaint, or that of a confidential informant, if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
[42] *Supra* note 40.

investigator, the complainant will be contacted and given the opportunity to provide additional information. A thorough investigation will be conducted. The steps taken in the investigation are determined by the specifics of the allegations, but generally include the following:

- Obtaining medical records, documents, and evidence;
- Locating and interviewing the complainant, the patient, the subject, and any witnesses; and
- Drafting and serving subpoenas for necessary information.

The ISU includes a staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders for the department.[43]

The PSU is responsible for providing legal services to the department in the regulation of all health care boards and councils. The PSU will review the investigative file and report from ISU and recommend a course of action to the State Surgeon General (when an immediate threat to the health, safety, and welfare of the people of Florida exists), the appropriate board's probable cause panel, or the department, if there is no board that may include:

- Having the file reviewed by an expert;
- Issuing a closing order (CO);
- Filing an administrative complaint (AC); or
- Issuing an emergency order (ERO or ESO).[44]

If the ISU investigative file received by PSU does not pose an immediate threat to the health, safety, and welfare of the people of Florida, then the PSU attorneys review the file and determine, first, whether expert review is required and, then, whether to recommend to the board's probable cause panel:

- A CO;
- An AC; or
- A Letter of guidance.[45,46]

A CO is recommended if the investigation and/or the expert opinion does not support the allegation(s). The subject and the complainant are notified of the results. The complainant may appeal the decision within 60 days of notification by providing additional information for consideration. Cases closed with no finding of probable cause are confidential and are not available through a public records request.[47]

An AC is recommended when the investigation and/or the expert opinion supports the allegation(s). The subject is entitled to a copy of the complete case file prior to the probable

[43] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited Mar. 9, 2021).
[44] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Prosecution Services*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited Mar. 9, 2021).
[45] Section 456.073(2), F.S. The department may recommend a letter of guidance in lieu of finding probable cause if the subject has not previously been issued a letter of guidance for a related offense.
[46] *Id.*
[47] *Supra* note 45.

cause panel meeting. When an AC is filed with the agency clerk, the subject has the right to choose one of the following options:

- *An Administrative Hearing Involving Disputed Issues of Material Fact* – The subject disputes the facts in the AC and elects to have a hearing before the Division of Administrative Hearings (DOAH).[48] If this occurs, all parties may be asked to testify and the administrative law judge will issue a recommended order that will then go to the board, or the department if there is no board, for final agency action.
- *A Settlement/Stipulation/Consent Agreement* – The subject enters into an agreement to be presented before the board or the department if there is no board. Terms of this agreement may impose penalties negotiated between the subject or the subject's attorney and the department's attorney.
- *A Hearing Not Involving Disputed Issues of Material Fact* – The subject of the AC does not dispute the facts. The subject elects to be heard before the board or the department if there is no board. At that time, the subject will be permitted to give oral and/or written evidence in mitigation or in opposition to the recommended action by the department.
- *Voluntary Relinquishment of License* – The subject of the AC may elect to surrender his or her license and to cease practice.[49]

Final department action, including all of the above, as well as cases where the subject has failed to respond to an AC, are presented before the applicable board, or the department if there is no board. The subject may be required to appear. The complainant is notified of the date and location of the hearing and may attend. If the subject is entitled to, and does appeal the final decision, PSU defends the final order before the appropriate appellate court.[50]

If the ISU investigative file received by the PSU presents evidence of an immediate threat to the health, safety, and welfare of the people of Florida, then PSU will present the file to the State Surgeon General and recommend one of two types of emergency orders – ESO or ERO – that are exclusively issued by the State Surgeon General against licensees who pose such a threat to the people of Florida.[51]

Whether the State Surgeon General issues an ERO or an ESO depends on the level of danger the licensee presents because the department is permitted to use only the "least restrictive means" to stop the danger.[52] The distinction between the two orders is:

- ESOs – Licensees are deemed to be a threat to the public at large; or
- EROs – Licensees are considered a threat to a segment of the population.[53]

The emergency order process is carried out without a hearing, restricting someone's right to work, and when the order is served on the licensee, it must contain a notice to the licensee of his

[48] *See* ss. 120.569 and 120.57, F.S.
[49] *Id.*
[50] *Supra* note 43.
[51] Section 456.073(8) and 120.60(6), F.S.
[52] Section 120.60(6)(b), F.S.
[53] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, Prosecution Services, *A Quick Guide to the MQA Disciplinary Process Discretionary Emergency Orders – 3 Things to Know, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/_documents/a-quick-guide-to-the-mqa-disciplinary-process-discrtionary-emergency-orders.pdf (last visited Mar. 9, 2021).

or her right to an immediate appeal of the emergency order.[54] An ESO or ERO is not considered final agency action, and the department must file an AC on the underlying facts supporting the ESO or ERO within 20 days of its issuance.[55] The appeal of the emergency order and the normal disciplinary process under the AC, and regular prosecution can run simultaneously.[56]

Mandatory EROs and ESOs

Section 456.074, F.S., directs that in certain cases, the department must issue an ESO or ERO to certain license practitioners under certain circumstances, specifically:

- If any of the following practitioners have plead guilty to, been convicted of, found guilty of, or have entered a plea of *nolo contendere* to, regardless of adjudication, Medicare fraud, Medicaid fraud, health care fraud, or reproductive battery, they are subject to an ESO by the State Surgeon General:
  - Allopathic physician, physician assistants, anesthesiologist assistants, medical assistants;
  - Osteopathic physician, physician assistants, and anesthesiologist assistants;
  - Chiropractic physician and physician assistants;
  - Podiatric physicians;
  - Naturopathic physicians;
  - Optometrists - licensed and certified;
  - Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses and certified nursing assistants;
  - Pharmacists and pharmacy technicians;
  - Dentists, dental hygienist and dental laboratories; and
  - Opticians[57]
- The department may issue an ESO or ERO if the Board of Medicine (BOM) or Board of Osteopathic Medicine (BOOM) has previously found one of its physicians has committed medical malpractice,[58] gross medical malpractice, or repeated medical malpractice,[59] and the probable cause panel again finds probable of cause for another malpractice violation. In such cases, the State Surgeon General must review the matter to determine if an ESO or ERO is warranted;[60]
- The department may issue an ESO or ERO if any practitioner governed by ch. 456, F.S., tests positive for any drug on any government or private sector pre-employment or employer-ordered confirmed drug test,[61] when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug;[62]

[54] *See* Fla. Admin. Code R. 28-106.501(3) (2020), and ss. 120.569(2)(n) or 120.60(6), F.S.
[55] Fla. Admin. Code R. 28-106.501(3) (2020).
[56] Section 120.60(6)(c), F.S.
[57] Section 456.073(1), F.S.
[58] Section 456.50(1)(g), F.S., "Medical malpractice" which is defined to mean the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in law related to health care licensure.
[59] *Id.* "Repeated medical malpractice" is medical malpractice, and any similar wrongful act, neglect, or default committed in another state or country that, if committed in this state, would have been considered medical malpractice, and will be considered medical malpractice, if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.
[60] Section 456.074(2), F.S.
[61] *See* s. 112.0445, F.S.
[62] Section 456.074(3), F.S. The practitioner must be given 48 hours from the time of notification of the confirmed test results to produce a lawful prescription for the drug before an emergency order is issued.

- The department must issue an ESO if it receives information that a massage therapist, a person with an ownership interest in the establishment, or a massage corporate establishment corporation whose owners, officers, or individual are directly involved in the management of the establishment, has been convicted of, found guilty of, or has entered a guilty or *nolo contendere* plea to, regardless of adjudication, a felony under any of the following crimes anywhere:[63]
  - Prostitution;[64]
  - Kidnapping;[65]
  - False imprisonment;[66]
  - Luring or enticing a child;[67]
  - Human trafficking;[68]
  - Human smuggling;[69]
  - Sexual battery;[70]
  - Female genital mutilation;[71]
  - Procuring a person under 18 for prostitution;[72]
  - Selling or buying of minors into prostitution;[73]
  - Forcing, compelling, or coercing another to become a prostitute;[74]
  - Deriving support from the proceeds of prostitution;[75]
  - Prohibiting prostitution and related acts;[76]
  - Lewd or lascivious offenses committed upon or in the presence of persons under 16;[77]
  - Lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person;[78]
  - Sexual performance by a child;[79]
  - Protection of minors;[80]
  - Computer pornography;[81]
  - Transmission of material harmful to minors, to a minor by electronic device or equipment;[82] and

[63] 456.074(4), F.S.
[64] Section 796.07(1)(a), F.S., "Prostitution" which is defined to mean the giving or receiving of the body for sexual activity for hire, but excludes sexual activity between spouses. Prostitution that took place at massage establishment is reclassified to the next higher degree. *See* s. 796.07(2)(a), F.S., that is reclassified under s. 796.07(7), F.S.
[65] Section 787.01, F.S.
[66] Section 787.02, F.S.
[67] Section 787.025, F.S.
[68] Section 787.06, F.S.
[69] Section 787.07, F.S.
[70] Section 794.011, F.S.
[71] Section 794.08, F.S.
[72] Former s. 796.03, F.S.
[73] Former s. 796.035, F.S.
[74] Section 796.04, F.S.
[75] Section 796.05, F.S.
[76] Section 796.07(4)(a)3., F.S., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, F.S.
[77] Section 800.04, F.S.
[78] Section 825.1025(2)(b), F.S.
[79] Section 827.071, F.S.
[80] Section 847.0133, F.S.
[81] Section 847.0135, F.S.
[82] Section 847.0138, F.S.

- Selling or buying of minors.[83]

- The department must issue an ESO if a BOM or BOOM probable cause panel determines that the following constitutes a violation of the practice act and there exists an immediate danger to the public:
  - The registered surgery office where office surgery liposuction, or Level II or Level III office surgeries are being performed, or the physician practicing in the office, are not in compliance with the standards of practice for office surgery set by statute and board rule;[84] or
  - The physician is practicing beyond the scope of his or her education, training, and experience and is performing procedures the licensee knows, or has reason to know, that he or she is not competent to perform.[85,86]

Due Process Under Chapter 120, F.S.

Chapter 120, F.S., known as the Administrative Procedure Act, provides uniform procedures for the exercise of specified authority. Section 120.60, F.S., pertains to licensing and provides for due process for persons seeking government-issued licensure or who have been granted such licensure. Section 120.60(5), F.S., provides that:

- No revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the entry of a final order, the governmental agency has served, by personal service or certified mail, an administrative complaint that affords reasonable notice to the licensee of facts or conduct that warrant the intended action and unless the licensee has been given an adequate opportunity to request a hearing under ss. 120.569 and 120.57, F.S.
- When personal service cannot be made and the certified mail notice is returned undelivered, the agency must cause a short, plain notice to the licensee to be published once each week for four consecutive weeks in a newspaper published in the county of the licensee's last known address as it appears on the records of the agency, or, if no newspaper is published in that county, the notice may be published in a newspaper of general circulation in that county.

Section 120.60(6), F.S., provides a process for cases that a governmental agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license. In such cases, the agency may take such action by any procedure that is fair under the circumstances if:

- The procedure provides at least the same procedural protection as is given by other statutes, the State Constitution, or the U.S. Constitution;
- The agency takes only that action necessary to protect the public interest under the emergency procedure; and
- The agency states in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety, or welfare and its reasons for concluding that the procedure used is fair under the circumstances. The agency's findings of immediate danger, necessity, and procedural fairness are judicially reviewable. Summary suspension, restriction, or limitation may be ordered, but a suspension or revocation

[83] Section 847.0145, F.S.
[84] *Id.* and Fla. Admin. Code Rs. 64B-9.009 and 64B15-14.007 (2020).
[85] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[86] Section 456.074(5), F.S.

proceeding pursuant to ss. 120.569 and 120.57, F.S., must also be promptly instituted and acted upon.

Anesthesiology

Under chs. 458 and 459, F.S., "anesthesiology" is defined as the practice of medicine that specializes in the relief of pain during and after surgical procedures and childbirth, during certain chronic disease processes, and during resuscitation and critical care of patients in the operating room and intensive care environments.[87]

The term "anesthesiologist" is defined as an allopathic or osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education or its equivalent; and who is certified by the American Board of Anesthesiology, is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.[88]

Anesthesiologist Assistants

"Anesthesiologist assistant" which is defined to mean a graduate of an approved program who is licensed by the BOM or BOOM to perform medical services delegated and directly supervised by a supervising anesthesiologist, under a written protocol with an anesthesiologist or group of anesthesiologists.[89]

"Direct supervision" which is defined to mean the onsite, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.[90]

An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by rule by the BOM or BOOM in any of various functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist, including:[91]

- Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.
- Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.
- Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

[87] Sections 458.3475(1)(c) and 459.023(1)(c), F.S.
[88] Sections 458.3475(1)(a) and 459.023(1)(a), F.S.
[89] Sections 458.3475(1)(b) and 459.023(1)(b), F.S.
[90] Sections 458.3475(1)(g) and 459.023(1)(g), F.S.
[91] Sections 458.3475(3)(a) and 459.023(3)(a), F.S.

- Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.
- Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.
- Administer anesthetic drugs, adjuvant drugs, and accessory drugs.
- Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.
- Administer blood, blood products, and supportive fluids.
- Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.
- Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.
- Participate in management of the patient while in the post-anesthesia recovery area, including the administration of any supporting fluids or drugs.
- Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

Nurse Anesthetists

A certified registered nurse anesthetist (CRNA) is an advance practice registered nurse (APRN), licensed by the BON, who specializes in anesthetic services.

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The BON provides, by rule, the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices.[92] Additionally, the BON is responsible for administratively disciplining an APRN who commits prohibited acts.[93]

In Florida "advanced or specialized nursing practice" includes, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the BON as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience.[94] Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[95] In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[96]

A CRNA may, to the extent authorized by established protocol approved by the medical staff of the facility that the anesthetic service is performed, perform any or all of the following:

- Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the patient through the performance of the general functions.

[92] *See* s. 464.004, F.S., and Fla. Admin. Code R. 64B9-3 (2020).
[93] *See* ss. 464.018 and 456.072, F.S.
[94] Section 464.003(2), F.S.
[95] Section 464.012(3)-(4), F.S.
[96] *Id.*

- Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.
- Order pre-anesthetic medication under the protocol.
- Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. These procedures include ordering and administering regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.
- Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.
- Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.
- Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.
- Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.
- Participate in management of the patient while in the post-anesthesia recovery area, including ordering the administration of fluids and drugs.
- Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

"Nurse Anesthesiologist"

On August 8, 2019, at the general BON meeting, the BON considered requests for declaratory statements.[97] The second request for a declaratory statement was made by John P. McDonough, A.P.R.N., C.R.N.A., license number 3344982.[98]

For the meeting, McDonough's Petition for Declaratory Statement acknowledged that the type of Florida nursing license he held was as an *A.P.R.N.*, and that he was a certified registered nurse anesthetist (C.R.N.A.), but requested that he be permitted to use the phrase "nurse anesthesiologist" as a descriptor for him or his practice, and that the BON not subject him to discipline under ss. 456.072 and 464.018, F.S.,[99] based on the following grounds:

[97] Section 120.565, F.S. Provides that, "[a]ny substantially affected person may seek a declaratory statement regarding an agency's opinion as to the applicability of a statutory provision as it applies to the petitioner's particular set of circumstances. The agency must give notice of the filing of a petition in the Florida Administrative Register, provide copies of the petition to the board, and issue a declaratory statement or deny the petition within 90 days after the filing. The declaratory statement or denial of the petition is then noticed in the next Florida Administrative Register, and disposition of a petition is a final agency action."

[98] The Florida Board of Nursing, Meeting Minutes, Disciplinary Hearings & General Business, *Declaratory Statements*, No. 2, Aug. 8, 2019, *available at* https://floridasnursing.gov/meetings/minutes/2019/08-august/08072019-minutes.pdf p. 28 (last visited Mar. 12, 2021).

[99] *Petition for Declaratory Statement Before the Board of Nursing, In re: John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, July 10, 2019 (on file with the Senate Committee on Health Policy).

- A New Hampshire Board of Nursing's Position Statement that the nomenclature, *Nurse Anesthesiologist* and *Certified Registered Nurse Anesthesiologist*, are not title changes or an expansion of scope of practice, but are optional, accurate descriptors;[100] and
- Florida law grants no title protection to the words *anesthesiologist* or *anesthetist.*[101]

The Florida Association of Nurse Anesthetists (FANA) and the Florida Medical Association, Inc. (FMA), Florida Society of Anesthesiologists, Inc. (FSA), and Florida Osteopathic Medical Association, Inc. (FOMA), filed timely and legally sufficient[102] motions to intervene[103] pursuant to Florida Administrative Code Rule 28-106.205.[104] The FANA's petition[105] was in support of petitioner's Declaratory Statement while the motion filed jointly by the FMA, FSA, and FOMA was in opposition.

The FMA, FSA, and FOMA argued they were entitled to participate in the proceedings, on behalf of their members, as the substantial interests of their members – some 32,300 – could be adversely affected by the proceeding.[106, 107] Specifically, the FMA, FSA, and FOMA argued that the substantial interests of their respective members would be adversely affected by the issuance of a Declaratory Statement that a petitioner could use the term "nurse anesthesiologist," without violating ss. 456.072 and 464.018, F.S., on the grounds that:

- A substantial number of their members use the term "anesthesiologist" with the intent and understanding that patients, and potential patients, would recognize the term to refer to them as physicians licensed under chs. 458 or 459, F.S., not "nurse anesthetists;"

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[100] New Hampshire Board of Nursing, *Position Statement Regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)*, Nov. 20, 2018, *available at* https://static1.squarespace.com/static/5bf069ef3e2d09d0f4e0a54f/t/5f6f8a708d2cb23bb10f50a0/1601145457231/NH+BON+NURSE+ANESTHESIOLOGIST.pdf (last visited Mar. 12, 2021).

[101] *Id.*

[102] Fla. Adm. Code R. 28-105.0027(2) and 28.106.205(2) (2019), both of which state that to be legally sufficient, a motion to intervene in a proceeding on a petition for a declaratory statement must contain the following information: (a) The name, address, the e-mail address, and facsimile number, if any, of the intervenor; if the intervenor is not represented by an attorney or qualified representative;(b) The name, address, e-mail address, telephone number, and any facsimile number of the intervener's attorney or qualified representative, if any; (c) Allegations sufficient to demonstrate that the intervenor is entitled to participate in the proceeding as a matter of constitutional or statutory right or pursuant to agency rule, or *that the substantial interests of the intervenor are subject to determination or will be affected by the declaratory statement;* (d) The signature of the intervener or intervener's attorney or qualified representative; and (e) The date.

[103] The Florida Medical Association, Inc., Florida Society of Anesthesiologists, Inc., and Florida Osteopathic Medical Association, Inc., *Motion to Intervene In Florida Board of Nursing's Consideration of the Petition for Declaratory Statement in Opposition of Petitioner John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, Aug. 1, 2019, (on file with the Senate Health Policy Committee).

[104] Fla. Adm. Code. R. 28-106.205 (2019), in pertinent part, provides, "Persons other than the original parties to a pending proceeding whose substantial interest will be affected by the proceeding and who desire to become parties may move the presiding officer for leave to intervene."

[105] *Florida Association of Nurse Anesthetists Motion to Intervene*, filed at the Department of Health, July 31, 2019, (on file with the Senate Committee on Health Policy).

[106] *Supra* note 104.

[107] *See Florida Home Builders Association, et al., Petitioners, v. Department of Labor And Employment Security, Respondent*, 412 S.2d 351 (Fla. 1982), holding that a trade association does have standing under s. 120.56(1), F.S., to challenge the validity of an agency ruling on behalf of its members when that association fairly represents members who have been substantially affected by the ruling.

- Sections 458.3475(1)(a) and 459.023(1)(a), F.S., both define the term "anesthesiologist" as a licensed allopathic or osteopathic physician and do not include in those definitions a "nurse anesthetist;"
- The Merriam-Webster Dictionary defines an "anesthesiologist" as a "physician specializing in anesthesiology," not as a nurse specializing in anesthesia; and
- The Legislature clearly intended a distinction between the titles to be used by physicians practicing anesthesiology and nurses delivering anesthesia, to avoid confusion, as s. 464.015(6), F.S., specifically states that:
  - Only persons who hold valid certificates to practice as certified registered nurse anesthetists in this state may use the title "Certified Registered Nurse Anesthetist" and the abbreviations "C.R.N.A." or "nurse anesthetist;" and
  - Petitioner is licensed as a "registered nurse anesthetist" under s. 464.012(1)(a), F.S., and the term "nurse anesthesiologist" is not found in statute.

At the hearing, the attorney for the BON advised the BON that, "[t]he first thing the Board need[ed] to do [was] determine whether or not the organizations that [had] filed petitions to intervene have standing in order to participate in the discussion of the Declaratory Statement"[108] and that:

> "Basically in order to make a determination of whether an organization has standing, they have to show that the members of their organization would have an actual injury in fact, or suffer an immediate harm of some sort of immediacy were the Board to issue this particular Declaratory Statement, and then the Board also has to make a determination of whether the nature of the injury would be within the zone of interest that the statute is addressing."[109]

However, the above special injury standard,[110] provided by board counsel to the BON to apply to determine the organizations' standing to intervene, based on their members' substantial interests being affected by the declaratory statement, was held inapplicable to trade associations in *Florida Home Builders Ass'n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982). The Florida Supreme Court, in *Florida Home Build*ers, *Ass'n.*, held that a trade or professional association is able to challenge an agency action on behalf of its members, even though each member could individually challenge the agency action, if the organization could demonstrate that:

- A substantial number of the association members, though not necessarily a majority, would be "substantially affected" by the challenged action;
- The subject matter of the challenged action is within the association's scope of interest and activity; and
- The relief requested is appropriate for the association's members.[111]

[108] Record at p. 3, ll. 13-17. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).
[109] *Id.* p. 3-4, ll. 22- 25, 1-6.
[110] *United States Steel Corp. v. Save Sand Key, Inc.*, 303 So.2d 9 (Fla. 1974).
[111] *Florida Home Builders Ass'n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982), pp. 353-354.

The FANA's motion to intervene was granted, based on the application of an incorrect standard, without the BON making the findings required by *Florida Home Build*ers, *Ass'n.* The motion to intervene filed by the FMA, FSA, and FOMA was denied, also based on the application of an incorrect standard, on the grounds that:

- Their members are regulated by the Board of Medicine, not the Board of Nursing;
- Nursing disciplinary guidelines were being discussed;
- Their members' licenses and discipline would not be affected by an interpretation of nursing discipline;[112] and
- Their members are not regulated by the Nurse Practice Act.

A motion was made to approve McDonough's Petition for Declaratory Statement, and it passed unanimously. According to the BON's approval, McDonough may now use of the term "nurse anesthesiologist" as a descriptor, and such use is not grounds for discipline against his nursing license. However, while s. 120.565, F.S., provides that any person may seek a declaratory statement regarding the potential impact of a statute, rule or agency opinion on a petitioner's particular situation, approval or denial of the petition only applies to the petitioner. It is not a method of obtaining a policy statement from a board of general applicability.[113] News media have reported that the BON's Declaratory Statement in favor of McDonough has created significant concern for patient safety and the potential for confusion in the use of the moniker "anesthesiologist" among Florida's medical professionals.[114,115,116]

III. Effect of Proposed Changes:

The bill amends s. 456.072(1)(a), F.S., that provides grounds for discipline applicable to all licensed health care practitioners, to:

- Add the making of misleading, deceptive, or fraudulent representations related to a practitioner's "specialty designation" as grounds for discipline, in addition to such representations related to the practice of practitioner's profession as under current law.
- Provide that the term "anesthesiologist" may be used only by a practitioner licensed under chs. 458 or 459, F.S., or licensed as a dentist under ch. 466, F.S.
- Provide that the term "dermatologist" may be used only by a practitioner licensed under chs. 458 or 459, F.S.

The bill requires that when the Department of Health (department) finds that a health care practitioner has violated s. 456.072(1)(a), F.S., pertaining to a specialty designation, as amended

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[112] Record at p. 7, ll. 1-13. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).
[113] Florida Department of Health, Board of Nursing, *What is a Declaratory Statement?, available at* https://floridasnursing.gov/help-center/what-is-a-declaratory-statement/ (last visited Mar. 9, 2021).
[114] Christine Sexton, The News Service of Florida, "*Nursing Board Signs Off On 'Anesthesiologist' Title,"* August 16, 2019, The Gainesville Sun, *available at*: https://www.gainesville.com/news/20190816/nursing-board-signs-off-on-anesthesiologist-title (last visited Mar. 9, 2021).
[115] Christine Sexton, The News Service of Florida, *"Florida Lawmaker Takes Aim At Health Care Titles*," October 10, 2019, Health News Florida, *available at* https://health.wusf.usf.edu/post/florida-lawmaker-takes-aim-health-care-titles (last visited Mar. 9, 2021).
[116] Christine Section, The News Service of Florida, "*What's In A Name? Health Panel Seeks Clarity on Health Care Providers,"* Nov. 14, 2019, *available at* https://health.wusf.usf.edu/post/what-s-name-health-panel-seeks-clarity-health-care-providers (last visited Mar. 9, 2021).

by the bill, the department must issue an emergency order to the practitioner to cease and desist from using the name or title, or any other words, letters, abbreviations, or insignia indicating that he or she may practice under the specialty designation. The bill requires the department to send the emergency cease and desist order to the practitioner by certified mail to the practitioner's physical address and to the email address of record on file with the department and to any other mailing address or email address that the department believes the practitioner may be reached.

If the practitioner does not cease and desist his or her actions in violation of s. 456.072(1)(a), F.S., as amended by the bill, immediately upon receipt of the emergency cease and desist order, the bill requires the department to enter an order imposing any of the following penalties, or a combination thereof, until the practitioner complies with the cease and desist order:

- A citation and a daily fine.
- A reprimand or a letter of concern.
- Suspension of license.

The bill also amends s. 456.072(1)(t), F.S., to provide that a licensed practitioner's failure to identify the specialty designation under which he or she is practicing – through written notice, that may include the wearing of a name tag, or orally to a patient – is grounds for disciplinary action. Under current law, such failure applies only to the type of license under which the practitioner is practicing. The bill also provides that the department, not a practitioner regulatory board, must enforce s. 456.072(1)(t), F.S., as amended by the bill.

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:

The bill's requirement for the Department of Health (department) to enter an order imposing penalties if a person does not immediately comply with an emergency cease and desist order – in a manner that differs from procedures that provide due process

under current law – may subject those provisions of the bill to challenge as a violation of the licensee's due process rights under the Florida Constitution and the U.S. Constitution.

Both the fifth and fourteenth amendments to the U.S. Constitution prohibit arbitrary deprivation of life, liberty, or property by the government except as authorized by law. The U.S. Supreme Court has interpreted these provisions broadly, ruling that they provide for procedural due process in civil and criminal proceedings and substantive due process, or a prohibition against vague laws. Article I, Section 9, of the Florida Constitution provides that no person must be deprived of life, liberty, or property without due process of law.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

A licensed health care practitioner found to be in violation of s. 456.072(1)(a), F.S., as amended by PCS/CS/SB 1142, may be subject to a daily fine imposed by the Department of Health if he or she fails to comply with a cease and desist order issued under the bill.

C. Government Sector Impact:

According to the Department of Health (department), the department will incur nonrecurring costs for rulemaking and they may experience a recurring increase in workload associated with additional complaints, investigations, and prosecutions resulting from the bill; however, it is anticipated that these can be absorbed within existing resources.[117]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Department of Health (department) advises that while the bill focuses on a practitioner's misuse of a specialty designation as grounds for discipline, the term "specialty designation" is not defined in the bill or in existing statute and is not a term used in the ordinary course of health care practitioner regulation. Absent a definition or guidelines about what constitutes a misrepresentation, the bill's new grounds for discipline are so vague as to be unenforceable, according to the department. While some physicians hold board certifications in their specialty areas from the American Board of Medical Specialties or the American Osteopathic Association, not all specialists hold or maintain such credentials. Health care providers who participate in Medicare typically have a specialty designation that they bill for payment. It is unclear to the

[117] Department of Health, *Senate Bill 1142 Fiscal Analysis* (Mar. 31, 2021) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

department what credentials a practitioner must hold to use a "specialty designation" under the bill and when the use of such designation would be considered misleading or fraudulent.[118]

The department also advises that, because the bill requires the department, not the applicable regulatory board, to impose discipline for violations of ss. 456.072(1)(a) and (t), F.S., the bill will require the creation of a new disciplinary process. The department will need to create a unique procedure and tracking system for these specific charges. For all other disciplinary grounds, it is the board that issued the license that takes disciplinary action against that license. The bill would authorize the department to suspend a practitioner's license without the involvement or input of the board that issued the license, that could be interpreted to conflict with current law regarding practitioner discipline.[119,120]

The department further advises that, under the bill's requirement for the department to issue an emergency order to cease and desist, the procedures for issuing such an order are unclear. Currently, when the department issues an emergency order, it must show that allowing the practitioner to continue to practice would constitute an immediate serious danger to the health, safety, or welfare of the citizens of Florida and that nothing short of the emergency action would protect citizens from that danger, as required under s. 120.60(6), F.S. It is unclear to the department how these requirements would be met under the circumstances specified in the bill.[121]

The department further advises that the bill's requirement for the department to enter an order imposing penalties if a person does not immediately comply with an emergency cease and desist order may conflict with s. 456.073(5), F.S., that provides that a formal hearing must be held before an administrative law judge in disciplinary matters if there are material issues of disputed fact. This portion of the bill may also conflict with s. 120.60(5), F.S., that provides that no revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the entry of the order, the governmental agency has served, by personal service or certified mail, an administrative complaint that affords reasonable notice to the licensee of facts or conduct that warrant the intended action and the licensee has been given an adequate opportunity to request a proceeding pursuant to ss. 120.569 and 120.57, F.S.[122]

VIII. Statutes Affected:

This bill substantially amends section 456.072 of the Florida Statutes.

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[118] *Id.*

[119] *Id.*

[120] Sections 456.073(1) and (2), F.S., provide that the department investigates complaints and violations of the grounds for discipline and provides the completed investigative report to the probable cause panel of the appropriate regulatory board. The statute provides for the report to be sent to the department only when there is no board for the profession in question. Section 456.073(4), F.S., provides that the determination of the existence of probable cause is made by the probable cause panel and that the department determines probable cause only if there is no board. And, s. 456.073(6), F.S., provides that the appropriate board issues the final order in each health care professional disciplinary case, unless there is no board, in that case the department would issue the final order.

[121] *Supra*, note 117.

[122] *Id.*

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 April 8, 2021:
The CS makes technical corrections to clarify that the Department of Health must take disciplinary actions specified in the bill only when a violation relating to a specialty designation has occurred, and only when health care practitioners, not other persons, have committed the violation.

CS by Health Policy on March 17, 2021:
The CS changes the underlying bill's amendment to s. 456.072(1)(a), F.S., to remove the requirement for practitioners licensed under chs. 458 or 459, F.S., to be physicians in order to use the terms "anesthesiologist" or "dermatologist." This addresses a technical deficiency in the underlying bill that would have prevented anesthesiologist assistants, who are non-physicians licensed under chs. 458 or 459, from using the term "anesthesiologist," even though the term appears in their license.

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

APPEARANCE RECORD

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

4/8/21
Meeting Date

1142
Bill Number (if applicable)

Topic Prohibited Acts by HealthCare Practitioners

Amendment Barcode (if applicable)

Name Steve Winn

Job Title Exec. Director

Address 2544 Blairstone Pines Dr Phone 878-7364
Street

Tallahassee FL 32301 Email
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

4/8/21
Meeting Date

SB 1142
Bill Number (if applicable)

Topic Prohibited Acts by Health Care Practitioners

Amendment Barcode (if applicable)

Name Alexandra Abboud

Job Title Governmental Affairs Liaison

Address 118 E Jefferson Street
Street

Phone 850-224-1089

Tallahassee FL 32301
City *State* *Zip*

Email aabboud@floridadental.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Dental Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

1142
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nyland

Job Title _____

Address 4427 Herschel St
Street
Jacksonville, FL 32210
City *State* *Zip*

Phone 904-233-3051

Email nylandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Society of Plastic Surgeons / Florida Society of Dermatology

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8/21
Meeting Date

1142
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Lyon

Job Title _____

Address 315 S. Calhoun St., Ste-830
Street

Phone 222-5702

Tallahassee FL 32301
City *State* *Zip*

Email clyon@flw-law.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Association of Nurse Anesthetists

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

By the Committee on Health Policy; and Senator Rodrigues

588-02989-21 20211142c1

A bill to be entitled

An act relating to prohibited acts by health care practitioners; amending s. 456.072, F.S.; subjecting health care practitioners to discipline for making misleading, deceptive, or fraudulent representations related to their specialty designations; specifying that only certain licensed health care practitioners may use the terms "anesthesiologist" or "dermatologist"; subjecting health care practitioners to discipline for failing to provide written or oral notice to patients of their specialty designation; requiring the department, instead of applicable health care practitioner boards, to enforce the written or oral notice requirement; requiring the department to issue emergency cease and desist orders to certain persons under certain circumstances; providing requirements for the notice of such emergency orders; requiring the department to impose certain administrative penalties if such persons do not immediately comply with the emergency orders; providing an effective date.

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

Section 1. Paragraphs (a) and (t) of subsection (1) and subsection (2) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which

588-02989-21 20211142c1

the disciplinary actions specified in subsection (2) may be taken:

(a) Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession or specialty designation. The term "anesthesiologist" may be used only if the practitioner is licensed under chapter 458 or chapter 459 or as a dentist under chapter 466, and the term "dermatologist" may be used only if the practitioner is licensed under chapter 458 or chapter 459.

(t) Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license or specialty designation under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. This paragraph does not apply to a practitioner while the practitioner is providing services in a facility licensed under chapter 394, chapter 395, chapter 400, or chapter 429. The department shall enforce this paragraph ~~Each board, or the department where there is no board, is authorized by rule to determine how its practitioners may comply with this disclosure requirement~~.

(2)(a) When the board, or the department when there is no board, finds any person guilty of the grounds set forth in subsection (1) or of any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) or a violation of the applicable practice act which occurred before ~~prior to~~ obtaining a license, it may enter an order imposing one or more of the following penalties:

1.~~(a)~~ Refusal to certify, or to certify with restrictions, an application for a license.

2.~~(b)~~ Suspension or permanent revocation of a license.

3.~~(c)~~ Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for the protection of the public health, safety, and welfare.

4.~~(d)~~ Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

5.~~(e)~~ Issuance of a reprimand or letter of concern.

6.~~(f)~~ Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

7.~~(g)~~ Corrective action.

8.~~(h)~~ Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights.

9.~~(i)~~ Refund of fees billed and collected from the patient or a third party on behalf of the patient.

10.~~(j)~~ Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

(b)1. When the department finds that a person has violated paragraph (1)(a), the department must issue an emergency order to the person to cease and desist from using the name or title, or any other words, letters, abbreviations, or insignia indicating that he or she may practice under the specialty designation. The department must send the emergency cease and desist order to the person by certified mail and e-mail to the person's physical address and e-mail address of record on file with the department and to any other mailing address or e-mail address through which the department believes the person may be reached.

2. If the person does not cease and desist his or her actions in violation of paragraph (1)(a) immediately upon receipt of the emergency cease and desist order, the department must enter an order imposing any of the following penalties, or a combination thereof, until the person complies with the cease

and desist order:

a. A citation and a daily fine.

b. A reprimand or a letter of concern.

c. Suspension of license.

Section 2. This act shall take effect upon becoming a law.

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

266254

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 101 - 116

and insert:

(b) When the department finds that a health care practitioner has violated the provisions of paragraph (1)(a) pertaining to a specialty designation:

1. The department must issue an emergency order to the practitioner to cease and desist from using the name or title, or any other words, letters, abbreviations, or insignia

266254

indicating that he or she may practice under the specialty designation. The department must send the emergency cease and desist order to the practitioner by certified mail and e-mail to the practitioner's physical address and e-mail address of record on file with the department and to any other mailing address or e-mail address through which the department believes the practitioner may be reached.

2. If the practitioner does not cease and desist his or her actions in violation of paragraph (1)(a) immediately upon receipt of the emergency cease and desist order, the department must enter an order imposing any of the following penalties, or a combination thereof, until the practitioner complies with the cease

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

And the title is amended as follows:

Delete lines 16 - 19

and insert:

health care practitioners under certain circumstances; providing requirements for the notice of such emergency orders; requiring the department to impose certain administrative penalties if such practitioners do not

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 1242 (246400)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Book
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	April 12, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1242 codifies the Program of All-Inclusive Care for the Elderly (PACE) in section 430.84, Florida Statutes. The bill:

- Establishes a statutory process for the review, approval, and oversight of future and current PACE organizations.
- Authorizes the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA), to approve entities that have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant to federal regulations.
- Requires all PACE organizations to meet specific quality and performance standards established by the federal CMS and the AHCA.
- Requires the AHCA to provide oversight and monitoring of Florida's PACE program and organizations.
- Exempts all PACE organizations from the requirements of ch. 641, F.S., which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

The bill has no fiscal impact on state revenues or expenditures. *See* Section V of this analysis.

The bill takes effect on July 1, 2021.

II. Present Situation:

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

To qualify for nursing home care under Medicaid, both an individual's income and assets are reviewed. Additionally, a personal needs allowance is applied as part of the eligibility determination process.[1] The current standard income limit in Florida for institutional care or services under the home and community based services waiver is $2,382 for an individual and $4,764 for a couple. There is also an asset limit for either category of $2,000 for an individual or $3,000 for a couple.[2]

In Florida, the Medicaid program is administered by the Agency for Health Care Administration (AHCA). The AHCA, however, delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), and the Department of Elder Affairs (DOEA). The AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services.

The DOEA assesses Medicaid recipients to determine if they require nursing home level of care. Specifically, the DOEA determines whether an individual requires or is at imminent risk of nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires:

- Medically complex care to be performed on a daily basis under the direct supervision of a health professional because of mental or physical incapacitation;
- Care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.[3]

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance.

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[1] The personal needs allowance (PNA) of an individual is defined as that portion of an individual's income that is protected to meet the individual's personal needs while in an institution. *See* Department of Children and Families (DCF), *Glossary (Chapter 4600) "Personal Needs Allowance," p. 19, available at* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf (last visited Mar. 16, 2021).

[2] DCF, *SSI-Related Program-Financial Eligibility Standards: Apr. 1, 2021, available at* https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf (last visited Mar. 16, 2021).

[3] Section 409.985, F.S.

Long-Term Care Managed Care

In 2011, Statewide Medicaid Managed Care (SMMC) was established,[4] requiring both Medicaid Long-Term Care (LTC) services and Managed Medical Assistance (MMA) services to be provided through managed care plans.

Long-Term Care Managed Care plans participating in SMMC are required to provide minimum benefits that include nursing home care as well as home and community based services. The minimum benefits include:

- Nursing home 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;
- Therapies, including physical, respiratory, speech, and occupational;
- Intermittent and skilled nursing;
- Medication administration;
- Medication management;
- Nutritional assessment and risk reduction;
- Caregiver training;
- Respite care;
- Transportation; and
- Personal emergency response system.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA)[5] that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing mechanism. The model was developed to address the needs of long-term care clients, providers, and payers.

The PACE operates as a three-way agreement between the federal government, the state administering agency, and a PACE organization. In Florida, the PACE is a Florida Medicaid LTC managed care plan option providing comprehensive long-term and acute care services which support Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[6]

[4] Chapter 2011-134, Laws of Fla.
[5] Specifically, services under the PACE are authorized under Section 1905(a)(26) of the Social Security Act.
[6] Department of Elder Affairs (DOEA) and Agency for Health Care Administration (AHCA), *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014),

The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver.

The federal government established the PACE organization requirements and application process; however, the state is responsible for oversight of the application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve participants. An approved PACE organization must sign a contract with the federal CMS and the state Medicaid agency, the AHCA.

The PACE is administered by the DOEA in consultation with the AHCA. The DOEA oversees the contracted PACE organizations but is not a party to the contract between the federal CMS, the AHCA, and the PACE organizations.[7] The DOEA, the AHCA, and the federal CMS must approve any applications for new PACE organizations if expansion is authorized by the Legislature through the necessary appropriation of the state matching funds.

PACE Organizations

A PACE organization is a private not-for-profit 501(c)(3) organization, for-profit private or public entity that is primarily engaged in providing PACE services and must also:

- Have a governing board that includes participant representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness;
- Have a formal participant bill of rights; and
- Have a process to address grievances and appeals.[8]

Eligibility and Benefits

To be eligible for PACE, an individual must:

- Be 55 years of age or older;
- Live within the defined service area of the PACE Center;
- Meet medical eligibility requirements as determined by a Comprehensive Assessment and Review of Long-Term Care Services (CARES);[9]

available at https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Mar. 31, 2021).

[7] *Id.*

[8] HHS, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Mar. 31, 2021).

[9] Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants. Federal law mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks

- Be able to live safely in the community; and
- Be dually eligible for Medicaid and Medicare, or Medicaid only. There is also a private pay option with PACE, however this is not regulated by the State.[10]

By federal law, the first three contract years for a PACE organization are considered a trial period, and the PACE organization is subject to annual reviews to ensure compliance.[11] Review of the PACE organization may continue after the trial period by the Secretary or the administering state agency as appropriate, depending upon the PACE organization's performance and compliance with requirements and regulations.

No deductibles, copayments, coinsurance, or other cost-sharing can be charged by a PACE organization. No other limits relating to amount, duration, or scope of services that might otherwise apply in Medicaid are permitted.[12] The PACE enrollee must accept the PACE center physician as his or her new Medicare primary care physician, if enrolled in Medicare.[13]

Quality of Care Requirements

Each PACE organization is required to develop, implement, maintain, and evaluate an effective data-driven Quality Assurance and Performance Improvement (QAPI) program. The program must incorporate all aspects of the PACE organization's operations, which allows for the identification of areas that need performance improvement. The organization's written QAPI plan must be reviewed by the PACE organization's governing body at least annually. At a minimum, the plan should address the following areas:

- Utilization of services in the PACE organization, especially in key services;
- Participant and caregiver satisfaction with services;
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period;
- Effectiveness and safety of direct and contracted services delivered to participants; and
- Outcomes in the organization's non-clinical areas.[14]

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to receive home and community-based services through Medicaid waivers like Familial Dysautonomia Waiver, and Statewide Medicaid Managed Care Long-Term Care Program. Any person or family member can initiate a CARES assessment by applying for the Medicaid Institutional Care Program (ICP). Assessments are completed at no cost to the clients and are performed by a registered nurse and/or assessor. DOEA, *Comprehensive Assessment and Review for Long-Term Care Services (CARES), available at* http://elderaffairs.state.fl.us/doea/cares.php (last visited Mar. 31, 2021).

[10] DOEA, *Program of All-Inclusive Care for the Elderly (PACE), available at* http://elderaffairs.state.fl.us/doea/pace.php (last visited Mar. 31. 2021).

[11] *See* 42 U.S.C. s. 1395eee(e)(4)(A) (2020).

[12] HHS, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Mar. 31, 2021).

[13] DOEA and AHCA, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Mar. 31, 2021).

[14] *Id.*

Florida PACE

The original Florida PACE project was authorized in 1998,[15] under the administration of the DOEA operating in consultation with the AHCA.[16] Florida's first PACE organization, located in Miami-Dade County, began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the General Appropriations Act (GAA) or general law.

In 2011, administrative responsibility for the PACE was moved from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the SMMC program.[17] Participation by the PACE in the SMMC program is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[18]

The current approval process for a new PACE project authorized by the Legislature requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. PACE providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that PACE providers in the same geographic region are not competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the PACE center, staffing for key positions, and signed provider network contracts, the AHCA certifies to the federal CMS that the PACE site is ready. At that time, the federal CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

Enrollment and Organizational Slots

Slots are authorized by the Legislature for a specific PACE area; however, slots may not always be fully funded in the same year the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations.

[15] Chapter 98-327, Laws of Fla.
[16] Chapter 2011-135, s. 24, Laws of Fla., repealed s. 430.707, F.S., effective October 1, 2013, as part of the expansion of Medicaid managed care.
[17] Chapter 2011-134, Laws of Fla.
[18] Section 409.981(4), F.S.

Funding and Rates

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through proviso language in the GAA or through one of the GAA's accompanying implementing or conforming bills.[19] These directives provide specific slot increases or decreases by county or authorization for implementation of a new program.

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government. The payment amount is established in the GAA and is based on estimates that have been forecast by the Social Services Estimating Conference for the PACE.

The Fiscal Year 2020-2021 GAA provided just over $73 million in PACE program funding to PACE organizations around the state.[20] The following table includes allocation and enrollment information outlined in the Fiscal Year 2020-2021 GAA:

Current PACE Programs[21]				
PACE Organization		**Enrollment**		
Service Area	**Organization**	**Authorized Slots**	**Funded Slots**	**Enrollment (Feb. 2021)[22]**
Broward	Florida PACE	150	125	99
Charlotte	Hope Select PACE	150	150	89
Clay, Duval	Northeast PACE Partners	300	150	57
Collier	Hope Select PACE	120	120	63
Lake, Orange, Osceola, Seminole, Sumter	InnovAge PACE	300	150	0
Lee	Hope Select PACE	380	380	260
Martin	Florida PACE	150	125	0
Miami-Dade	Florida PACE	828	828	816
Palm Beach	Morse PACE	706	706	649
Pinellas	Empath PACE	325	325	314
Total		**3,409**	**3,059**	**2,347**

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE) within the Florida Statutes. Currently, the program does not have an implementing statute and has been operationalized through annual appropriations, proviso, or bills designed to implement the state budget or conform statute to provisions of the state budget. In addition, the bill:

[19] Chapter 2013-40, Laws of Fla.
[20] Chapter 2020-111, Laws of Fla.
[21] Email from the DOEA, (March 9, 2021) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[22] AHCA, *Florida Statewide Medicaid Monthly Enrollment Report* (February 28, 2021), *available at* https://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Mar. 31, 2021).

- Authorizes the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA), to approve entities that have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant to 42 U.S.C. s. 1395eee. Applications, as required by the federal CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must be published in the Florida Administrative Register.
- Requires a prospective PACE organization to submit an application to the AHCA before submitting a request for program funding. An applicant must meet the following requirements:
  - Provide evidence that the applicant can meet all of the federal regulations and requirements established by the federal CMS by the proposed implementation date;
  - Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve; and
  - Develop and provide a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Requires each applicant to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be authorized to provide services within any unique and defined geographic area.
- Authorizes a PACE organization that has received funding for slots in a given geographic area to use the funding and slots to provide services in an authorized contiguous geographic area, upon approval from the AHCA.
- Requires an existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the AHCA to show evidence of regulatory compliance and meet market study requirements.
- Requires any prospective PACE organization that is granted initial state approval by the AHCA, in consultation with the DOEA, to submit its complete federal PACE application to the AHCA and the federal CMS within 12 months after date of initial state approval. If the organization fails to timely meet this requirement, the state approval of the application is void.
- Requires all PACE organizations to meet specific quality and performance standards established by the federal CMS and the state administering agency (the AHCA). The AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations through the data and reports submitted periodically to the AHCA and the federal CMS.
- Exempts all PACE organizations from the requirements of chapter 641, the chapter of Florida law that regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

Section 2 provides an effective date of July 1, 2021.

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:

Additional private sector providers that meet the criteria to be a Program of All-Inclusive Care for the Elderly (PACE) organization and achieve eligibility confirmation status could be approved as PACE sites. Expansion of PACE sites would also mean additional individuals in the community would have access to the PACE model for medical care and long-term care.

C. Government Sector Impact:

PCS/CS/SB 1242 poses a minor operational impact to the AHCA, however, the workload can be absorbed using existing agency resources. Although the bill does not direct the AHCA to initiate rulemaking in conjunction with the new statutory language, the AHCA would need to utilize existing statutory authority to promulgate an administrative rule to clearly outline the AHCA's standard business operation. This can also be completed using existing agency resources.[23]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[23] AHCA, *House Bill 905 Fiscal Analysis* (Feb. 12, 2021) (on file with Senate Committee on Health Policy).

VIII. Statutes Affected:

This bill creates section 430.84 of the Florida Statutes.

IX. Additional Information:

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

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on April 8, 2021:
The CS authorizes a Program of All-Inclusive Care for the Elderly (PACE) organization that has received funding for slots in a given geographic area to use the funding and slots to provide services in an authorized contiguous geographic area, upon approval from the Agency for Health Care Administration (AHCA).

CS by Health Policy on March 24, 2021:
The CS requires all PACE organizations to meet specific quality performance standards established by the federal CMS and the state administering agency (the AHCA), rather than just the federal CMS.

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: March 25, 2021

I respectfully request that **Senate Bill 1242**, relating to Program of All-Inclusive Care for the Elderly, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Thank you for your consideration.

Lauren Book

Senator Lauren Book
Florida Senate, District 32

THE FLORIDA SENATE

APPEARANCE RECORD

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

4-8-21
Meeting Date

1242
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic PACE

Name Cliff Bauer

Job Title VP Gov Relations / Pres. FL PACE Centers

Address 5200 NE 2nd Ave
Street
Miami FL 33137
City *State* *Zip*

Phone 954-465-7431

Email cbauer@miamijewishhealth.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida PACE Centers / Miami Jewish Health

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/8
Meeting Date

1242
Bill Number (if applicable)

155134
Amendment Barcode (if applicable)

Topic SB 1242 PACE

Name Matt Hudson

Job Title Executive Director

Address 9420 Healthpark Circle
Street

Phone 2392487107

Fort Myers FL 33907
City *State* *Zip*

Email Matt.Hudson@FLPACE.org

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

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

Representing Florida PACE Provider Association

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

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

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

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

S-001 (10/14/14)

By the Committee on Health Policy; and Senator Book

588-03330-21 20211242c1

A bill to be entitled

An act relating to the Program of All-Inclusive Care for the Elderly; creating s. 430.84, F.S.; defining terms; authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve entities applying to deliver PACE services in the state; requiring applications to be reviewed and considered on a continuous basis; requiring notice of applications to be published in the Florida Administrative Register; providing specified application requirements for such prospective PACE organizations; requiring existing PACE organizations to meet specified requirements under certain circumstances; requiring prospective PACE organizations to submit a complete application to the agency and the Centers for Medicare and Medicaid Services within a specified period; requiring that PACE organizations meet certain federal and state quality and performance standards; requiring the agency to oversee and monitor the PACE program and organizations; providing that a PACE organization is exempt from certain requirements; providing an effective date.

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

Section 1. Section 430.84, Florida Statutes, is created to read:

430.84 Program of All-Inclusive Care for the Elderly.—

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

588-03330-21 20211242c1

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

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

(b) "Applicant" means an entity that has filed an application with the agency for consideration as a Program of All-Inclusive Care for the Elderly (PACE) organization.

(c) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(d) "Department" means the Department of Elderly Affairs.

(e) "PACE organization" means an entity under contract with the agency to deliver PACE services.

(f) "Participant" means an individual receiving services from a PACE organization who has been determined by the department to need the level of care required under the state Medicaid plan for coverage of nursing facility services.

(2) PROGRAM CREATION.—The agency, in consultation with the department, may approve entities that have submitted applications required by the CMS to the agency for review and consideration which contain the data and information required in subsection (3) to provide benefits pursuant to the PACE program as established in 42 U.S.C. s. 1395eee and in accordance with the requirements set forth in this section.

(3) PACE ORGANIZATION SELECTION.—The agency, in consultation with the department, shall, on a continuous basis, review and consider applications required by the CMS for PACE that have been submitted to the agency by entities seeking initial, state approval to become PACE organizations. Notice of such applications shall be published in the Florida

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

Administrative Register.

(a) A prospective PACE organization shall submit application documents to the agency before requesting program funding. Application documents submitted to and reviewed by the agency, in consultation with the department, must include all of the following:

1. Evidence that the applicant has the ability to meet all of the applicable federal regulations and requirements, established by the CMS, for participation as a PACE organization by the proposed implementation date.

2. Market studies, including an estimate of the number of potential participants and the geographic service area in which the applicant proposes to serve.

3. A business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

(b) Each applicant must propose to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be authorized to provide services within any unique and defined geographic service area.

(c) An existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the agency or Legislature shall meet the requirements set forth in paragraphs (a) and (b).

(d) Any prospective PACE organization that is granted initial state approval by the agency, in consultation with the department, shall submit its complete federal PACE application, in accordance with the application process and guidelines

established by the CMS, to the agency and the CMS within 12 months after the date of initial state approval, or such approval is void.

(4) ACCOUNTABILITY.—All PACE organizations must meet specific quality and performance standards established by the CMS and the state administering agency for the PACE program. The agency shall oversee and monitor the PACE program and organizations based upon data and reports periodically submitted by PACE organizations to the agency and the CMS. A PACE organization is exempt from the requirements of chapter 641.

Section 2. This act shall take effect July 1, 2021.

155134

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
	.	
	.	
	.	

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

Senate Amendment

Between lines 79 and 80
insert:
(c) Upon agency approval, a PACE organization that is authorized to provide and has received funding for PACE slots in a given geographic area may use such slots and funding to serve the needs of participants in a contiguous geographic area if such PACE organization is authorized to provide PACE services in that area.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1292
INTRODUCER:	Health Policy Committee and Senator Bean
SUBJECT:	Medicaid
DATE:	April 7, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1292 updates or repeals outdated or obsolete language relating to:

- Reimbursement of prescribed drugs based on average wholesale price;
- Implementation of, including increases and decreases to, a variable pharmacy dispensing fee;
- Review of certain drugs by the Medicaid Pharmaceutical and Therapeutics Committee;
- Duties of the Department of Children and Families regarding Medicaid Fair Hearings;
- Providing prior "authorizations" rather than "consultations" for pharmacy services;
- Expansion of mail order delivery of pharmacy products;
- Medicaid reimbursement of drugs prescribed to treat erectile dysfunction;
- The definition of "medical necessity;" and
- The Organ Transplant Advisory Council.

The bill also eliminates requirements that the Agency for Health Care Administration (AHCA) submit reports to the Legislature that are obsolete or outdated related to the Pharmaceutical Expense Assistance Program, the Medicaid Reform 1115 Waiver, and Fee-for-Service Pharmaceutical spending.

The bill does not have a fiscal impact on the Florida Medicaid program. *See* Section V of this analysis.

The bill takes effect on July 1, 2021.

II. Present Situation:

Due to the diverse range of issues within the bill, additional background information is provided within the effect of proposed changes section of this analysis for the reader's convenience.

The Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state and is responsible for, among other things, the administration of the Florida Medicaid program, and 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, and licenses, certifies, regulates or provides exemptions for more than 48,000 providers.[1]

Florida Medicaid Program

The Medicaid program is a partnership between the federal and state governments that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[2] The federal Centers for Medicare and Medicaid Services (CMS) within the United States Department of Health and Human Services is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians and is administered by the AHCA, and financed through state and federal funds.[3]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[4]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services

[1] *See* Agency for Health Care Administration (AHCA), Division of Health Quality Assurance *available at* http://ahca.myflorida.com/MCHQ/index.shtml (last visited Mar. 31, 2021).
[2] Medicaid.gov, *Medicaid*, *available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 3, 2021).
[3] Section 20.42, F.S.
[4] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Mar. 3, 2021).

for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[5] The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care program. Florida's SMMC offers a health care package covering both acute and long-term care.[6] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014, and the current contracts expire in 2024.[7]

III. Effect of Proposed Changes:

Pharmaceutical Expense Assistance Program Report

The Pharmaceutical Expense Assistance Program was established within the AHCA in 2006 to provide pharmaceutical expense assistance to individuals diagnosed with cancer or individuals who have received organ transplants who were medically needy recipients prior to January 1, 2006, and who are eligible for Medicare.[8] Using Medicaid payment policies, the AHCA pays Medicare Part B prescription drug coinsurance and deductibles for Medicare Part B medications that treat eligible cancer and organ transplant patients.[9]

The initial program was funded with $3.7 million and approximately 650 people were identified as potentially eligible for the program. Only those unique individuals identified as eligible at the time of the program's passage are eligible and, as a result, program size and expenditures have reduced significantly. The program currently pays pharmacy expenses for approximately 20 individuals who meet that criteria, requiring a total expenditure of $4,457 during Fiscal Year 2019-2020.[10]

The AHCA is currently required to submit an annual report to the Legislature on the operation of the program. The annual report must include information on the number of individuals served, use rates, and expenditures under the program.

Section 1 of the bill amends s. 402.81, F.S., to eliminate the requirement that the AHCA submit a report to the Legislature by January 1 of each year on the operation of the Pharmaceutical Expense Assistance Program.

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[5] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Mar. 3, 2021).
[6] *Id.*
[7] Chapter 2020-156, s. 44, Laws of Fla.
[8] Chapter 2006-28, s. 20, Laws of Fla.; Section 402.81(1) and (2), F.S.
[9] Section 402.81(3), F.S.
[10] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).

Drug Pricing Formula

The AHCA is required to reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in agency rule.[11] Florida law specifies that a provider of prescribed drugs must be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the AHCA, plus a dispensing fee.[12]

On February 1, 2016, the federal CMS published a final rule, effective April 1, 2017, that requires states to update reimbursement methodologies for covered outpatient drugs in the Medicaid program.[13] The requirements of this rule include a revised federal regulation requiring states to reimburse at an aggregate upper limit based on actual acquisition cost plus a professional dispensing fee established by the state Medicaid agency.[14]

While states retained the flexibility to establish reimbursement methodologies consistent with the requirements of this final rule, Florida's statutory reimbursement methodology does not align with the new federal requirements. In response, the AHCA amended its reimbursement methodology for covered outpatient drugs.[15] Changes in the bill would update the statutory reimbursement methodologies so they are in line with the federal rules and with the AHCA's current practice.[16]

Section 3 of the bill amends s. 409.908(14), F.S., and **Section 5** of the bill amends s. 409.912(5)(a), F.S., to make changes to provisions setting reimbursement rates for providers of prescribed drugs. Currently, a provider of prescribed drugs must be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The Medicaid maximum allowable fee for ingredient cost must be based on the lowest of: the average wholesale price minus 16.4 percent, the wholesaler acquisition cost plus 1.5 percent, the federal upper limit, the state maximum allowable cost, or the usual and customary charge billed by the provider. Under the bill, a provider of prescribed drugs will be reimbursed in an amount not to exceed the lesser of the actual acquisition cost based on the federal CMS National Average Drug Acquisition Cost pricing files plus a professional dispensing fee, the wholesale acquisition cost plus a professional dispensing fee, the state maximum allowable cost plus a professional dispensing fee, or the usual and customary charge billed by the provider.

Section 4 of the bill reenacts s. 409.91195(4), F.S., to incorporate the changes made to s. 409.912(5)(a), F.S.

[11] Section 409.908, F.S.
[12] Sections 409.908(14) and 409.912(5)(a), F.S.
[13] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).
[14] 42 CFR s. 447.512(b)
[15] Fla. Admin. Code R. 59G-4.251 (2020).
[16] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).

Variable Dispensing Fee

In addition to reimbursement for a prescription drug's cost, Medicaid pays pharmacies a professional dispensing fee for filling the prescription.

The AHCA is currently required to implement a variable dispensing fee for prescribed drugs. The AHCA is authorized to increase the dispensing fee by $0.50 for the dispensing of a drug on the Medicaid preferred drug list and to reduce the dispensing fee by $0.50 for drugs not on the preferred drug list.[17]

Effective April 1, 2017, federal CMS implemented the use of the term "professional dispensing fee" and mandated that certain criteria be met in setting the dispensing fee.[18] In response, the AHCA updated the Medicaid state plan with a new professional dispensing fee that does not conform to s. 409.908(14)(b) and (c), F.S. **Section 3** of the bill deletes these obsolete paragraphs.

Medicaid Preferred Drug List and Patient Safety

Established in 2000, the Medicaid Pharmaceutical and Therapeutics Committee (Committee) is composed of four allopathic physicians, one osteopathic physician, five pharmacists, and a consumer representative, each appointed by the Governor.[19] The Committee must meet at least quarterly and is responsible for developing, implementing, updating, and providing the AHCA with the Medicaid Preferred Drug List.[20]

Section 4 of the bill amends s. 409.91195(9), F.S., to remove language requiring the AHCA to ensure that any therapeutic class of drugs, including drugs that have been removed from distribution to the public by their manufacturer or the federal Food and Drug Administration (FDA) or have been required to carry a black box warning label by the federal FDA because of safety concerns, is reviewed by the Committee at the "next regularly scheduled meeting." Under current law, after such review, the Committee must recommend whether to retain the therapeutic class of drugs or subcategories of drugs within a therapeutic class on the Medicaid preferred drug list and whether to institute prior authorization requirements necessary to ensure patient safety.

If drugs covered by Florida Medicaid are removed from distribution for safety reasons or because of an FDA-mandated black box warning, the AHCA does not wait for the quarterly committee meetings or for its recommendations because the safety of enrollees could be at stake.[21]

Medicaid Fair Hearings

Individuals who have been turned down for a Medicaid service, or who were receiving a Medicaid service that has been was reduced or stopped, should receive a letter explaining why

[17] Section 409.908(14), F.S.
[18] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).
[19] AHCA, *Medicaid Pharmaceutical & Therapeutics Committee*, *available at* https://ahca.myflorida.com/medicaid/prescribed_drug/pharm_thera/ (last visited Mar. 22, 2021). *See* s. 409.91195, F.S.
[20] *Id.*
[21] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).

Medicaid will not pay for or cover the service.[22] In these cases, the individual has the right to challenge that determination in a Medicaid fair hearing.[23] Medicaid fair hearing responsibilities were moved from the Department of Children and Families (DCF) to the AHCA in 2016.[24]

Section 4 of the bill amends s. 409.91195(10), F.S., to reflect that the AHCA is responsible for Medicaid fair hearings in which preferred drug formulary decisions are appealed, rather than the DCF.

Prior Consultation and Prior Authorization

The AHCA is required to establish procedures ensuring that there is a response to a request for prior consultation by telephone or other communication device within 24 hours after receipt of a request for prior consultation.[25] Prior authorization means a process by which a health care provider must qualify for payment coverage by obtaining advance approval from a health plan before a specific service is delivered to the patient.[26]

Section 5 of the bill amends that provision to change prior "consultation" to prior "authorization." The AHCA does not provide pharmacy consultations, as that responsibility lies with the pharmacist.[27]

Home Delivery of Pharmacy Products

Since 2011, the AHCA has been required to "expand" home delivery of pharmaceuticals.[28] This provision predates the implementation of the SMMC program and the current Medicaid Pharmacy services rule.[29] The AHCA reports that this language is no longer needed because Medicaid FFS and managed care plans already provide for mail order delivery of drugs.

Section 5 deletes the outdated provisions requiring the AHCA to expand home delivery of pharmacy products.

Erectile Dysfunction Drugs

In 2005, federal law was amended to prohibit Medicaid federal financial participation for drugs used for the treatment of sexual or erectile dysfunction, unless such drugs were approved by the federal Food and Drug Administration to treat a different condition.[30] The Florida Medicaid

[22] AHCA, *Medicaid Fair Hearings*, *available at* https://ahca.myflorida.com/medicaid/complaints/fair_hrng.shtml (last visited Mar. 22, 2021).
[23] *Id.*
[24] Chapter 2016-65, Laws of Fla.
[25] Section 409.912(5)(a), F.S
[26] Riley, Hannah, Gistia Healthcare, *Making Sense of Prior Authorization, What is it?* (Apr. 21, 2020) *available at* https://www.gistia.com/insights/what-is-prior-authorization (last visited Mar. 22, 2021).
[27] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy)..
[28] Section 409.912(5)(a), F.S.
[29] *Id.*
[30] *Id.*

program is currently authorized to reimburse any drug prescribed to treat erectile dysfunction, limited to one dose per month.[31] This authorization predates the federal prohibition.

Section 5 deletes the provision limiting the doses of sexual or erectile dysfunction drugs, as Florida Medicaid does not cover such drugs based on the 2005 prohibition.

Medicaid Fee-for-Service Pharmaceutical Quarterly Report

The AHCA is currently required to submit quarterly reports to the Legislature on the implementation of a Medicaid prescribed-drug spending-control program for the FFS delivery system.[32] The reporting requirement has been in place since 2010 and pre-dates the implementation of the SMMC program and therefore, the cost controls described are no longer applicable to most Medicaid recipients in Florida. Fee-for-service Medicaid recipients are typically not enrolled in managed care due to specific health needs, the presence of other insurance, or because they are living in a facility that provides their prescription drugs. The results of the report do not generally reflect the Medicaid population.

Section 5 eliminates the requirement that the AHCA report quarterly to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the progress made on implementing s. 409.912(5), F.S., relating to Medicaid prescribed drug spending and its effect on expenditures.

Medicaid Reform 1115 Waiver Report

The AHCA is required to submit to the Legislature quarterly progress reports and annual reports that are submitted to the federal CMS for the 1115 Managed Medical Assistance waiver which is tied to the original 2006 Medicaid Reform waiver authority. The Medicaid Reform pilot program ended in 2014 with the full implementation of the SMMC program. These reports are now obsolete. All federal CMS-mandated reports regarding the SMMC waiver are posted on the AHCA's website to ensure transparency about the waiver.[33]

Section 6 of the bill repeals s. 409.91213, F.S., to eliminate the requirement that the AHCA submit a quarterly progress report and an annual report relating to the 1115 Managed Medical Assistance waiver to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability.

[31] Section 409.912(5)(a), F.S.
[32] Section 409.912 (5)(c), F.S.
[33] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).

Medical Necessity

Federal law specifies that state Medicaid programs do not have to cover services that are not medically necessary.[34] Each state has adopted its own definition of "medical necessity."[35] Section 409.913(1)(d), F.S., specifies that the AHCA is the final arbiter of medical necessity for purposes of medical reimbursement. Further, that paragraph requires determinations of medical necessity to be made by a licensed physician employed by or under contract with the AHCA, based upon information available *at the time the goods or services are provided*.

Pursuant to Rule 59G-1.010 of the Florida Administrative Code, care, goods, and services are medically necessary if they are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Section 7 of the bill amends s. 409.913, F.S., to create an exception to the requirement that determinations of medical necessity must be made by a licensed physician employed by or under contract with the AHCA. The exception enables doctoral-level, board-certified behavior analysts to make determinations of medical necessity for behavior analysis services in addition to licensed physicians. The bill also requires a determination of medical necessity to be based on information available at the time the goods or services are requested, rather than when they are provided. This change will bring Florida law into line with federal regulations.[36]

Organ Transplant Advisory Council

Section 765.53, F.S., establishes the Organ Transplant Advisory Council (OTAC) to consist of 12 physician members who are appointed to represent the interests of the public and the clients of the Department of Health or the AHCA. All members are appointed by the Secretary of Health Care Administration for two-year terms. The OTAC is responsible for recommending indications for adult and pediatric organ transplants to the AHCA and formulating guidelines and standards for organ transplants and for the development of End Stage Organ Disease and Tissue/Organ Transplant programs. The OTAC's recommendations, guidelines, and standards are limited in applicability to only those health programs funded through the AHCA.

[34] 42 U.S.C. s. 1395y.
[35] Dickey, Elizabeth, NOLO, Getting Approval for Medicaid Services: Medical Necessity *available at* https://www.nolo.com/legal-encyclopedia/getting-approval-medicaid-services-medical-necessity.html (last viewed Mar. 22, 2021).
[36] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).

The OTAC met 22 times with its first meeting held on August 27, 2007, and its last meeting held on April 14, 2015.[37]

Most actions of the OTAC revolved around approving guidelines for organ transplantations and reviewing and approving hospital transplant program applications for recommendation to the AHCA, which have been adopted into rule and into the Medicaid State Plan.[38] The AHCA indicates that the duties and responsibilities of the OTAC have become redundant because of federal CMS oversight, the Organ Procurement and Transplantation Network, the federal Health Resources and Services Administration, the United Network for Organ Sharing, Organ Procurement Organizations, the Foundation for the Accreditation of Cellular Therapy, and the Joint Commission.[39] The non-statutory function of the OTAC (recommending approval of transplant programs to the Secretary of Health Care Administration for Medicaid-designation) could be undertaken by staff of the AHCA.[40]

Section 8 of the bill repeals s. 765.53, F.S., to dissolve the OTAC by eliminating its statutory authority. **Section 2** of the bill amends s. 409.815, F.S., to delete a reference to the OTAC which would be dissolved under such repeal.

Section 9 of the bill provides an effective date of July 1, 2021.

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.

[37] AHCA, *Organ Transplant Advisory Council Meeting Information*, *available at* https://ahca.myflorida.com/medicaid/organ_transplant/meetings.shtml (last viewed Mar. 19, 2021).
[38] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).
[39] *Id.*
[40] *Id.*

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The AHCA reports that the bill will not have a fiscal impact on the Medicaid program, nor have any impact on recipients or providers.[41]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 402.81, 409.815, 409.908, 409.91195, 409.912, and 409.913.

This bill repeals the following sections of the Florida Statutes: 409.91213 and 765.53.

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 March 24, 2021:
The CS reinstates the current requirement in s. 409.908(2)(b), F.S., for the AHCA to submit an annual report related to nursing home direct and indirect care costs to the Legislature.

The CS also reinstates the current requirement in s. 409.913(d), F.S., that a determination of medical necessity must be made by a licensed physician, but also creates an exception for behavior analysis services by authorizing a doctoral-level, board-certified behavior analyst to make a determination of medical necessity, in addition to a licensed physician. The CS also reinstates and revises the current requirement for a determination of medical necessity to be based upon information available at the time the goods and services are "requested," rather than when they are "provided."

[41] AHCA, *Senate Bill 1292 Fiscal Analysis* (Feb. 19, 2021) (on file with the Senate Committee on Health Policy).

B. Amendments:

None.

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

By the Committee on Health Policy; and Senator Bean

588-03321-21 20211292c1

A bill to be entitled

An act relating to Medicaid; amending s. 402.81, F.S.; deleting a requirement for the Agency for Health Care Administration to submit an annual report to the Legislature on the operation of the pharmaceutical expense assistance program; amending s. 409.815, F.S.; conforming a provision to changes made by the act; amending s. 409.908, F.S.; revising the method for determining prescribed drug provider reimbursements; deleting a requirement for the agency to implement certain fees for prescribed medicines; deleting authorization for the agency to increase certain dispensing fees by certain amounts; reenacting and amending s. 409.91195, F.S., relating to the Medicaid Pharmaceutical and Therapeutics Committee; deleting a requirement for the agency to ensure that the committee reviews certain drugs under certain circumstances; designating the agency, rather than the Department of Children and Families, as the administrator for certain hearings; amending s. 409.912, F.S.; requiring the agency to establish certain procedures related to prior authorization requests rather than prior consultation requests; revising the method for determining prescribed drug provider reimbursements; deleting a requirement for the agency to expand home delivery of pharmacy products; deleting a dosage limitation on certain drugs; deleting a requirement for the agency to submit certain quarterly reports to the Governor and the

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Legislature; repealing s. 409.91213, F.S., relating to quarterly progress reports and annual reports; amending s. 409.913, F.S.; revising the definitions of the terms "medical necessity" and "medically necessary" to provide an exception for behavior analysis services determinations; requiring that determinations be based on information available at the time goods or services are requested, rather than at the time such goods or services are provided; repealing s. 765.53, F.S., relating to the Organ Transplant Advisory Council; providing an effective date.

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

Section 1. Subsection (4) of section 402.81, Florida Statutes, is amended to read:

402.81 Pharmaceutical expense assistance.—

(4) ADMINISTRATION.—The agency shall administer the pharmaceutical expense assistance program ~~shall be administered by the agency,~~ in collaboration with the Department of Elderly Affairs and the Department of Children and Families. ~~By January 1 of each year, the agency shall report to the Legislature on the operation of the program. The report shall include information on the number of individuals served, use rates, and expenditures under the program.~~

Section 2. Paragraph (e) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.—

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(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(e) *Organ transplantation services.*—Covered services include pretransplant, transplant, and postdischarge services and treatment of complications after transplantation for transplants deemed necessary and appropriate within the guidelines set by the ~~Organ Transplant Advisory Council under s. 765.53 or the~~ Bone Marrow Transplant Advisory Panel under s. 627.4236.

Section 3. Subsection (14) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected

retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(14) A provider of prescribed drugs shall be reimbursed in an amount not to exceed the lesser of the actual acquisition cost based on the Centers for Medicare and Medicaid Services National Average Drug Acquisition Cost pricing files plus a professional dispensing fee, the wholesale acquisition cost plus a professional dispensing fee, the state maximum allowable cost plus a professional dispensing fee, or the usual and customary charge billed by the provider ~~the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The Medicaid maximum allowable fee for ingredient cost must be based on the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider~~.

(a) Medicaid providers must dispense generic drugs if available at lower cost and the agency has not determined that the branded product is more cost-effective, unless the prescriber has requested and received approval to require the branded product.

(b) ~~The agency shall implement a variable dispensing fee for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred drug list products.~~

~~(c) The agency may increase the pharmacy dispensing fee authorized by statute and in the General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred drug list.~~

~~(d)~~ The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee.

(c) ~~(e)~~ The agency may limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

Section 4. Subsections (9) and (11) of section 409.91195, Florida Statutes, are amended, and subsection (4) of that section is reenacted for the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in a reference thereto, to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list as described in s. 409.912(5). To the extent feasible, the committee shall review all drug classes included on the preferred drug list every 12 months, and may recommend additions to and deletions from the preferred drug list, such that the preferred drug list provides for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

~~(9) Upon timely notice, the agency shall ensure that any therapeutic class of drugs which includes a drug that has been removed from distribution to the public by its manufacturer or the United States Food and Drug Administration or has been required to carry a black box warning label by the United States Food and Drug Administration because of safety concerns is reviewed by the committee at the next regularly scheduled meeting. After such review, the committee must recommend whether to retain the therapeutic class of drugs or subcategories of drugs within a therapeutic class on the preferred drug list and whether to institute prior authorization requirements necessary to ensure patient safety.~~

(10)~~(11)~~ Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the Agency for Health Care Administration ~~Department of Children and Families~~.

Section 5. Paragraphs (a) and (c) of subsection (5) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a

provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records,

clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(5)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal

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waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior authorization ~~consultation~~ by telephone or other telecommunication device within 24 hours after receipt of a request for prior authorization ~~consultation~~; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. A provider of prescribed drugs is reimbursed in an amount not to exceed the lesser of the actual acquisition cost based on the Centers for Medicare and Medicaid Services National Average Drug Acquisition Cost pricing files plus a professional dispensing fee, the wholesale acquisition cost plus a professional dispensing fee, the state maximum allowable cost plus a professional dispensing fee, or the usual and customary charge billed by the provider ~~Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider~~.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using

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significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other

entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

5. The agency shall develop and implement a program that requires Medicaid practitioners who issue written prescriptions for medicinal drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by prescribers who issue written prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper

limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

8.a. ~~The agency shall expand home delivery of pharmacy products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. The agency may seek and implement any~~

~~federal waivers necessary to implement this subparagraph.~~

~~9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.~~

~~10.a.~~ The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in

their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

9.~~11.~~ The agency shall implement a Medicaid prescription drug management system.

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this

program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

10.~~12.~~ The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes

with manufacturers, and maintaining a database of rebate collections.

11.~~13.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

12.~~14.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

13.~~15.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet

the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

14.~~16.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective,

or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

15.~~17.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

~~(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.~~

Section 6. Section 409.91213, Florida Statutes, is repealed.

Section 7. Paragraph (d) of subsection (1) of section

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409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with

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discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of

medical necessity must be made by a licensed physician employed by or under contract with the agency, except for behavior analysis services, which may be determined by a licensed physician or a doctoral-level board-certified behavior analyst. Determinations ~~and~~ must be based upon information available at the time the goods or services are requested ~~provided~~.

Section 8. Section 765.53, Florida Statutes, is repealed.

Section 9. This act shall take effect July 1, 2021.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	PCS/SB 1976 (410084)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services and Senator Brodeur
SUBJECT:	Freestanding Emergency Departments
DATE:	April 12, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

I. Summary:

PCS/SB 1976 amends multiple sections of law to establish a stronger distinction between freestanding emergency departments (FED) and urgent care centers (UCC). The bill:

- Establishes specific transparency requirements for FEDs, including requirements to post certain information in and around the facility that clearly identifies it as a FED, as well as information related to facility fees and network providers.
- Provides requirements for FED advertisements.
- Clarifies that FEDs operating as hospital-based UCCs and providing urgent care services that are not billed at emergency department rates are exempt from some of the sign and advertisement requirements.
- Requires the Agency for Health Care Administration (AHCA) to publish the following information on its website, and update at least annually:
  - A description of the differences between a FED and UCC;
  - At least two examples illustrating the cost difference between non-emergent care provided in a hospital emergency department setting and a UCC;
  - An interactive tool to locate local UCCs; and
  - Information on what to do in the event of a true emergency.
- Requires hospitals to post a link to the information AHCA publishes on its website in a prominent location on their websites.
- Creates an emergency room billing acknowledgement form with specific disclosure requirements and requires FEDs that bill for urgent care services to provide the form to patients receiving emergency medical treatment.
- Requires a health insurer to publish the following information on its website, and update at least annually:
  - A comparison of average in-network and out-of-network UCC and FED charges for the 30 most common UCC services;

- At least two examples illustrating the cost difference between non-emergent care provided in a hospital emergency department setting and a UCC; and
- An interactive tool to locate local in-network and out-of-network UCCs.

The bill has an insignificant negative impact to state expenditures that the AHCA can absorb with existing agency resources. *See* Section V of this analysis.

The bill takes effect on July 1, 2021.

II. Present Situation:

Off-Site Emergency Departments

With an increasing demand for emergency medical services and issues of overcrowding in existing emergency facilities, hospitals have begun to expand their emergency department services to off-site locations. Off-site emergency departments provide 24-hour emergency medical services at a distinct location, separate from the facility's central campus. Any Florida-licensed hospital that has a dedicated emergency department may provide emergency services in a location off of the hospital's main premises. Off-site emergency departments must be under the same direction, offer the same services, and comply with the same regulatory requirements as the emergency department located on the hospital's main premises.

Basic services include, but are not limited to:
- Ambulance delivery.
- Integrated hospital services.
- Distribute medications.
- Continuous operations (available 24-hours a day, 365 days a year).
- Medical screenings, examinations and evaluations by a physician, or authorized personnel under the supervision of a physician.[1]

There are no additional rules or standards specific for emergency departments located off the premises of the licensed hospital.[2]

Hospitals desiring to offer off-site emergency departments must meet the physical plant review requirements of s. 395.0163, F.S. The Agency for Health Care Administration (AHCA) must review the facility's plans and specifications before any construction begins. Reviews are also conducted during the construction phase, and final physical plant approval is granted when the facility is determined to meet all applicable hospital building codes.[3]

There are currently 86 off-site emergency departments operated by 58 hospitals in Florida.[4]

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[1] Agency for Health Care Administration (AHCA), *Consumer Guides, Emergency and Urgent Care, available at* *https://www.floridahealthfinder.gov/reports-guides/urgent-care-guide.aspx#OffSiteED* (last visited Apr. 1, 2021).
[2] AHCA, *House Bill 1157 Fiscal Analysis* (Feb. 23, 2021) (on file with the Senate Committee on Health Policy).
[3] AHCA, *Emergency Services, available at* https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Hospitals/EmergencyServices.shtml, (last visited Mar. 19, 2021).
[4] AHCA, *House Bill 1157 Fiscal Analysis* (Feb. 23, 2021) (on file with the Senate Committee on Health Policy).

Emergency Department Utilization and Charges

Although the total number of patients treated in an emergency department (ED)[5] has increased since 2008, the number of patients treated who were considered low-acuity[6] has dropped nearly 60 percent. In 2008, the number of patients treated in an ED who reported with a low-acuity problem was nearly 33 percent of all patients seen. By 2018, those numbers had dropped to approximately 12 percent.[7]

Despite the fact that the percentage of patients using EDs for low-acuity problems is trending downward, the overall volume of patients is still high. In 2018, EDs saw an approximate total of 9 million patients. At 12 percent, this indicates that just over 1 million patients used EDs for nonemergent medical issues. Patients using EDs for such problems could see significant charges billed. For example, in 2018, treatment for an upper respiratory infection averaged a $2,772 charge; treatment for abdominal pain averaged a $10,506 charge; and treatment for a urinary tract infection averaged a $7,598 charge.[8]

Urgent Care Centers

There is no specific licensure program for urgency care centers (UCCs). A UCC may be operated by a hospital, one or more clinicians, or by other persons or entities. Hospitals report off-site emergency departments, outpatient surgical locations, and other wholly-owned off-site outpatient locations through the hospital licensure process. The hospital's other outpatient locations are identified by name and address only, not services. Clinicians, other persons, and entities operating a UCC may be licensed as a health care clinic under ch. 400, Part X, F.S., or meet an exemption to the health care clinic licensure requirements.[9]

There are currently 212 UCCs in Florida.[10] In 2018, the average charge for a patient seen in a UCC was $193.[11]

Hospital-based Urgent Care Centers

Hospital-based UCCs are walk-in clinics owned and operated by a hospital and offer ambulatory care services outside of the traditional emergency room setting. Unlike emergency departments, UCCs typically operate during designated business hours and do not offer ambulance delivery services to the general public. However, based on their proximity to the hospital, hospital-based UCCs have the capacity to afford integrated hospital services to patients under their direct care.

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[5] In all emergency departments (EDs), not just off-site EDs.
[6] Requiring only straightforward or low complexity medical decision making and usually presenting with problems that are minor or are of low to moderate severity. *See* AHCA, *Emergency Department Utilization Report 2018,* p. 22, *available at* https://fhfstore.blob.core.windows.net/documents/researchers/documents/ED%20Report%202018%20Final.pdf (last visited Mar. 19, 2021).
[7] *Id.* at pp. 8 and 9.
[8] *Id.* at p. 10.
[9] AHCA, *House Bill 1157 Fiscal Analysis* (Feb. 23, 2021) (on file with the Senate Committee on Health Policy).
[10] *See* Florida Health Finder report, *available at* https://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx, (last visited Mar. 19, 2021).
[11] *See* https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf (last visited Mar. 19, 2021).

Basic services include, but are not limited to:
- Ambulatory care (outpatient medical care, including, but not limited to, diagnosis, observation, treatment, consultation, intervention, and rehabilitation services).
- Prescriptions for medications.
- Arrangements for additional or long-term health care services.
- Integrated hospital services.

While the AHCA does not license hospital-based UCCs separately, they must comply with the ambulatory care requirements found in hospital licensure regulations. Hospital-based UCCs are required to publish a schedule of charges for medical services offered to patients. Posted schedules must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be at least 15 square feet in size, displayed in a conspicuous location within the reception area of the UCC, and must include the 50 services most frequently provided by the clinic.[12]

Physician-based Urgent Care Centers

Physician-based UCCs are owned and operated by a physician or group of physicians and offer ambulatory medical treatment for non-life-threatening conditions on a walk-in basis. A typical physician-based UCC is a freestanding office operating during designated business hours, usually staffed by at least one physician, several medical assistants, nurses, and other health care professionals. These facilities are usually not equipped to offer integrated hospital services to individuals and will normally refer patients to either a primary care physician or specialist for advanced testing and/or treatment.

Basic services include, but are not limited to:
- Ambulatory care (diagnosis and treatment of non-life-threatening conditions, such as minor cuts or burns, the flu, or sinus infections).
- Prescriptions for medications.
- Arrangements for advanced or long-term health care services.

While the AHCA does license and regulate health care clinics, there are currently no separate licensure requirements for UCCs. However, a physician-based UCC may hold and maintain a health care clinic license, depending on the nature of its operation. Like all UCCs, physician-based UCCs are subject to the same charge schedule publishing requirements outlined above.[13]

Health Care Clinic-based Urgent Care Center

Much like physician-based urgent care facilities, health care clinic-based UCCs typically offer ambulatory medical treatment for members of the community on a walk-in basis. These facilities usually provide medical care services to individuals at little to no cost and could potentially be a viable option for members of the community that are either uninsured or cannot afford treatment.

[12] AHCA, *Consumer Guides, Emergency and Urgent Care, available at* *https://www.floridahealthfinder.gov/reports-guides/urgent-care-guide.aspx#OffSiteED* (last visited Apr. 1, 2021).
[13] *Id*.

Additionally, while the AHCA does license and regulate health care clinics, there are currently no separate licensure requirements for UCCs. However, a health care clinic-based UCC must maintain an active health care clinic license.[14]

III. Effect of Proposed Changes:

The bill amends multiple sections of law related to freestanding emergency departments (FEDs) and urgent care centers (UCCs).

Section 1 amends s. 395.002, F.S., to define "freestanding emergency department" as a facility that:

- Provides emergency services and care;
- Is owned and operated by a licensed hospital and operates under the hospital's license; and
- Is located on separate premises from the hospital.

The bill also removes off-site emergency departments from the definition of a UCC and makes other conforming changes.

Section 2 amends s. 395.003, F.S., to repeal obsolete language prohibiting the Agency for Health Care Administration (AHCA) from approving any FEDs prior to July 1, 2006.

Section 3 amends s. 395.1041, F.S., to:

- Prohibit FEDs from holding themselves out to the public as UCCs, unless that site is operating as a hospital-based UCC and providing urgent care services that are not billed at emergency department rates.
- Require FEDs to identify themselves as hospital emergency departments using, at a minimum, prominent, lighted signage with the word "EMERGENCY" and the name of the hospital.
- Require FEDs to post conspicuous signs at locations readily accessible and visible to patients outside entrances and in waiting areas that must specify the facility's average facility fee, and notify the public that the facility or a physician providing care at the facility may be an out-of-network provider. The signs must measure at least two square feet and the text must be in at least 36 point type. The signs must include the following statements:
  - "THIS IS A HOSPITAL EMERGENCY DEPARTMENT";
  - "THIS IS NOT AN URGENT CARE CENTER"; and
  - "EMERGENCY DEPARTMENT RATES ARE BILLED FOR OUR SERVICES."
- Allow a FED that shares a location and public entrance with a UCC that operates as a hospital-based UCC and provides urgent care services that are not billed at emergency department rates to also state "AND URGENT CARE SERVICES" in addition to any other FED required sign statements.
- Require any advertisement for a FED that does not provide and bill for urgent care services as a hospital-based UCC to include the statement "This emergency department is not an urgent care center. It is part of (insert hospital name) and its services and care are billed at hospital emergency department rates." Additionally, any billboard advertising a FED that does not provide and bill for urgent care services as a hospital-based UCC which measures at

[14] *Id*.

least 200 square feet must include the following statement at least 15 inches high "(INSERT NAME OF HOSPITAL) EMERGENCY DEPARTMENT. THIS IS NOT AN URGENT CARE CENTER."

- Require the AHCA to post on its website, and update annually, information that provides a description of the difference between FEDs and UCCs, including:
  - At least two examples illustrating the impact on insured and insurer paid amounts of inappropriate utilization of nonemergent services and care in a hospital emergency department setting compared to utilization of nonemergent services and care in an urgent care center;
  - An interactive tool to locate local urgent care centers; and
  - What to do in the event of a true emergency.
- Require hospitals to post a link to the information AHCA publishes on its website in a prominent location on their websites.
- Creates an emergency room billing acknowledgement form with specific disclosure requirements and requires FEDs that bill for urgent care services to provide the form to patients receiving emergency medical treatment. The form must include the following:
  - "Your visit today will be billed as an emergency room visit"; and
  - "I, (insert patient's name), understand that today's visit will be BILLED AS AN EMERGENCY ROOM VISIT. I certify that the (insert hospital name) has not withheld, delayed, or conditioned a medical screening examination or stabilizing care based upon any payment related concerns. I understand that I may qualify for financial assistance if I am unable to pay for my care today."

Section 4 amends s. 627.6405, F.S., to eliminate legislative intent language regarding the inappropriate use of EDs and to require health insurers to post on their websites, and update at least annually, a comparison of average in-network and out-of-network UCC and FED charges for the 30 most common UCC services, at least two examples of the impact on insured and insurer paid amounts of the inappropriate utilization of emergency departments for nonemergent services, and an interactive tool to locate local in-network and out-of-network UCCs.

Sections 5 through 12 amend ss. 385.211, 390.011, 394.4787, 395.701, 400.9935, 409.905, 409.975, 468.505, 627.64194, and 765.101, F.S., to make conforming changes.

Section 15 provides an effective date of July 1, 2021.

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/SB 1976 may have an indeterminate negative fiscal impact on hospitals with FEDs due to the increased requirements of signage. The bill may have an indeterminate positive fiscal impact on patients who pay for health care out of pocket and if they decide to seek treatment for low-acuity health issues at UCCs rather than FEDs. The bill may have an indeterminate positive fiscal impact on health insurers if insureds choose to use lower-cost UCCs rather than FEDs for low-acuity health issues.

C. Government Sector Impact:

The AHCA indicates that the bill's requirement for an interactive tool to be placed on the agency's website will require approximately $15,000 to cover contracted services, but this amount can be absorbed within existing agency resources.[15]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.002, 395.003, 395.1041, 627.6405, 385.211, 390.011, 394.4787, 395.701, 400.9935, 409.905, 409.975, 468.505, 627.64194, and 765.101.

[15] AHCA, *House Bill 1157 Fiscal Analysis* (Feb. 23, 2021) (on file with the Senate Committee on Health Policy).

IX. Additional Information:

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

Recommended CS by Appropriations Subcommittee on Health and Human Services on April 8, 2021:
The committee substitute:

- Clarifies that freestanding emergency departments (FED) operating as hospital-based urgent care centers (UCC) and providing urgent care services that are not billed at emergency department rates are:
  - Exempts from some of the sign and advertisement requirements; and
  - Allowed to state "AND URGENT CARE SERVICES" on required signs if they share a location and public entrance with a UCC.
- Creates an emergency room billing acknowledgement form with specific disclosure requirements and requires FEDs that bill for urgent care services to provide the form to patients receiving emergency medical treatment.
- Makes 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

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

Subject: Committee Agenda Request

Date: March 24, 2021

I respectfully request that **Senate Bill 1976**, relating to **Freestanding Emergency Departments**, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Jason Brodeur

Senator Jason Brodeur
Florida Senate, District 9

File signed original with committee office

By Senator Brodeur

9-01437-21 20211976__

A bill to be entitled

An act relating to freestanding emergency departments; amending s. 395.002, F.S.; defining and revising terms; amending s. 395.003, F.S.; deleting an obsolete provision relating to a prohibition on new emergency departments located off the premises of licensed hospitals; amending s. 395.1041, F.S.; prohibiting a freestanding emergency department from holding itself out to the public as an urgent care center; requiring a freestanding emergency department to clearly identify itself as a hospital emergency department using certain signage; requiring a freestanding emergency department to post signs in certain locations which contain specified statements; providing requirements for such signs; providing requirements for the advertisement of freestanding emergency departments; requiring the Agency for Health Care Administration to post information on its website describing the differences between a freestanding emergency department and an urgent care center; requiring the agency to update such information on its website at least annually; requiring hospitals to post a link to such information on their websites; amending s. 627.6405, F.S.; deleting legislative findings and intent; requiring health insurers to post certain information regarding appropriate use of emergency care services on their websites and update such information at least annually; revising the definition of the term "emergency care"; amending ss. 385.211, 390.011, 394.4787, 395.701, 400.9935, 409.905, 409.975, 468.505, 627.64194, and 765.101, F.S.; conforming cross-references; providing an effective date.

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Florida Senate - 2021 **SB 1976**

9-01437-21 20211976__

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

Section 1. Present subsections (10) through (32) of section 395.002, Florida Statutes, are redesignated as subsections (11) through (33), respectively, a new subsection (10) is added to that section, and present subsections (10), (27), and (29) are amended, to read:

395.002 Definitions.—As used in this chapter:

(10) "Freestanding emergency department" means a facility that:

(a) Provides emergency services and care;

(b) Is owned and operated by a licensed hospital and operates under the license of the hospital; and

(c) Is located on separate premises from the hospital.

(11) ~~(10)~~ "General hospital" means any facility which meets the provisions of subsection (13) ~~(12)~~ and which regularly makes its facilities and services available to the general population.

(28) ~~(27)~~ "Specialty hospital" means any facility which meets the provisions of subsection (13) ~~(12)~~, and which regularly makes available either:

(a) The range of medical services offered by general hospitals~~,~~ but restricted to a defined age or gender group of the population;

(b) A restricted range of services appropriate to the

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diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (16) ~~(15)~~.

(30)~~(29)~~ "Urgent care center" means a facility or clinic that provides immediate but not emergent ambulatory medical care to patients. ~~The term includes an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent medical care is provided.~~ The term ~~also~~ includes:

(a) An offsite facility of a facility licensed under this chapter, or a joint venture between a facility licensed under this chapter and a provider licensed under chapter 458 or chapter 459, that does not require a patient to make an appointment and is presented to the general public in any manner as a facility where immediate but not emergent medical care is provided.

(b) A clinic organization that is licensed under part X of chapter 400, maintains three or more locations using the same or a similar name, does not require a patient to make an appointment, and holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided.

Section 2. Paragraph (c) of subsection (1) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)

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

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~~authorized by the agency.~~

Section 3. Paragraph (m) is added to subsection (3) of section 395.1041, Florida Statutes, to read:

395.1041 Access to emergency services and care.—

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

(m)1. A freestanding emergency department may not hold itself out to the public as an urgent care center and must clearly identify itself as a hospital emergency department using, at a minimum, prominent lighted external signage that includes the word "EMERGENCY" in conjunction with the name of the hospital.

2. A freestanding emergency department shall conspicuously post signs at locations that are readily accessible to and visible by patients outside the entrance to the facility and in patient waiting areas which state the following: "THIS IS A HOSPITAL EMERGENCY DEPARTMENT." Unless the freestanding emergency department shares a location and a public entrance with an urgent care center, the signs must also state the following: "THIS IS NOT AN URGENT CARE CENTER. HOSPITAL EMERGENCY DEPARTMENT RATES ARE BILLED FOR OUR SERVICES." The signs must also specify the facility's average facility fee, if any, and notify the public that the facility or a physician providing medical care at the facility may be an out-of-network provider. The signs must be at least 2 square feet in size and the text must be in at least 36-point type.

3. Except as provided in this paragraph, any advertisement for a freestanding emergency department must include the following statement: "This emergency department is not an urgent

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care center. It is part of (insert hospital name) and its services and care are billed at hospital emergency department rates." Any billboard advertising a freestanding emergency department which measures at least 200 square feet must include the following statement in clearly legible contrasting color text at least 15 inches high: "(INSERT NAME OF HOSPITAL) EMERGENCY DEPARTMENT. THIS IS NOT AN URGENT CARE CENTER."

4.a. The agency shall post on its website information that provides a description of the differences between a freestanding emergency department and an urgent care center. Such description must include:

(I) At least two examples illustrating the impact on insured and insurer paid amounts of inappropriate utilization of nonemergent services and care in a hospital emergency department setting compared to utilization of nonemergent services and care in an urgent care center;

(II) An interactive tool to locate local urgent care centers; and

(III) What to do in the event of a true emergency.

b. The agency shall update the information required in sub-subparagraph a. at least annually. Each hospital shall post a link to such information in a prominent location on its website.

Section 4. Section 627.6405, Florida Statutes, is amended to read:

627.6405 Decreasing inappropriate utilization of emergency care.—

(1) ~~The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care,~~

~~but with the double-digit increases in health insurance premiums, health care providers and insurers should encourage patients and the insured to assume responsibility for their treatment, including emergency care. The Legislature finds that inappropriate utilization of emergency department services increases the overall cost of providing health care and these costs are ultimately borne by the hospital, the insured patients, and, many times, by the taxpayers of this state. Finally, the Legislature declares that the providers and insurers must share the responsibility of providing alternative treatment options to urgent care patients outside of the emergency department. Therefore, it is the intent of the Legislature to place the obligation for educating consumers and creating mechanisms for delivery of care that will decrease the overutilization of emergency service on health insurers and providers.~~

~~(2)~~ A health insurer ~~insurers~~ shall post ~~provide~~ on its website ~~their websites~~ information regarding appropriate utilization of emergency care services which shall include, but need not be limited to:~~,~~

(a) A list of alternative urgent care contracted providers;~~,~~

(b) The types of services offered by these providers;~~,~~

(c) A comparison of statewide average in-network and out-of-network urgent care center and freestanding emergency department charges for the 30 most common urgent care center services;

(d) At least two examples illustrating the impact on insured and insurer paid amounts of inappropriate utilization of

nonemergent services and care in a hospital emergency department setting compared to utilization of nonemergent services and care in an urgent care center;

(e) An interactive tool to locate local in-network and out-of-network urgent care centers; and

(f) What to do in the event of a true emergency.

Health insurers shall update the information required in this subsection on its website at least annually.

(2) ~~(3)~~ Health insurers shall develop community emergency department diversion programs. Such programs may include, at the discretion of the insurer, but not be limited to, enlisting providers to be on call to insurers after hours, coordinating care through local community resources, and providing incentives to providers for case management.

(3) ~~(4)~~ As a disincentive for insureds to inappropriately use emergency department services for nonemergency care, health insurers may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. Higher copayments may not be charged for the utilization of the emergency department for emergency care. For the purposes of this section, the term "emergency care" has the same meaning as the term "emergency services and care" as defined ~~provided~~ in s. 395.002(9) ~~s. 395.002~~ and includes ~~shall include~~ services provided to rule out an emergency medical condition.

Section 5. Subsection (2) of section 385.211, Florida Statutes, is amended to read:

385.211 Refractory and intractable epilepsy treatment and

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research at recognized medical centers.—

(2) Notwithstanding chapter 893, medical centers recognized pursuant to s. 381.925, or an academic medical research institution legally affiliated with a licensed children's specialty hospital as defined in s. 395.002(28) ~~s. 395.002(27)~~ that contracts with the Department of Health, may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC cannabis for the treatment for refractory or intractable epilepsy. The authority for recognized medical centers to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities described in this section.

Section 6. Subsection (7) of section 390.011, Florida Statutes, is amended to read:

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

(7) "Hospital" means a facility as defined in s. 395.002(13) ~~s. 395.002(12)~~ and licensed under chapter 395 and part II of chapter 408.

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

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

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(28) ~~s. 395.002(27)~~ and part II of chapter 408 as a specialty psychiatric hospital.

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

Section 8. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

(1) For the purposes of this section, the term:

(c) "Hospital" means a health care institution as defined in s. 395.002(13) ~~s. 395.002(12)~~, but does not include any hospital operated by a state agency.

Section 9. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous place in the reception area of any clinic that is considered an urgent care center as defined in s. 395.002(30)(b) ~~s. 395.002(29)(b)~~ and must include, but is not limited to, the 50 services most frequently provided by the clinic. 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 considered an urgent care center, to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 10. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

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

(8) NURSING FACILITY SERVICES.—The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(11) ~~s. 395.002(10)~~, that is licensed under part I of chapter 395, and in accordance with ~~provisions set~~

~~forth in~~ s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available. The agency shall pay only for bed-hold days if the facility has an occupancy rate of 95 percent or greater. The agency is authorized to seek any federal waivers to implement this policy.

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

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

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

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

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in

s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28) ~~s. 395.002(27)~~.

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

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 12. Paragraph (l) of subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.—

(1) Nothing in this part may be construed as prohibiting or restricting the practice, services, or activities of:

(l) A person employed by a nursing facility exempt from licensing under s. 395.002(13) ~~s. 395.002(12)~~, or a person

exempt from licensing under s. 464.022.

Section 13. Paragraph (b) of subsection (1) of section 627.64194, Florida Statutes, is amended to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

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

(b) "Facility" means a licensed facility as defined in s. 395.002(17) ~~s. 395.002(16)~~ and an urgent care center as defined in s. 395.002.

Section 14. Subsection (2) of section 765.101, Florida Statutes, is amended to read:

765.101 Definitions.—As used in this chapter:

(2) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient while the patient receives such treatment or care in a hospital as defined in s. 395.002(13) ~~s. 395.002(12)~~.

Section 15. This act shall take effect July 1, 2021.

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

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2021	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 95 - 138

and insert:

itself out to the public as an urgent care center, unless that site is operating in accordance with s. 395.107 and provides urgent care services that are not billed at emergency department rates, and must clearly identify itself as a hospital emergency department using, at a minimum, prominent lighted external signage that includes the word "EMERGENCY" in conjunction with

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the name of the hospital.

2. A freestanding emergency department shall conspicuously post signs at locations that are readily accessible to and visible by patients outside the entrance to the facility and in patient waiting areas which state the following: "THIS IS A HOSPITAL EMERGENCY DEPARTMENT." Unless the freestanding emergency department shares a location and a public entrance with an urgent care center, the signs must also state the following: "THIS IS NOT AN URGENT CARE CENTER. HOSPITAL EMERGENCY DEPARTMENT RATES ARE BILLED FOR OUR SERVICES." The signs must also specify the facility's average facility fee, if any, and notify the public that the facility or a physician providing medical care at the facility may be an out-of-network provider. The signs must be at least 2 square feet in size and the text must be in at least 36-point type. A freestanding emergency department that shares a location and public entrance with an urgent care center that operates in accordance with s. 395.107 and does not bill patients at emergency department rates may also state "AND URGENT CARE SERVICES" in addition to any signage requirements required by this paragraph.

3. Except as provided in this paragraph, any advertisement for a freestanding emergency department that does not provide and bill for urgent care services in accordance with s. 395.107 must include the following statement: "This emergency department is not an urgent care center. It is part of (insert hospital name) and its services and care are billed at hospital emergency department rates." Any billboard advertising a freestanding emergency department that does not provide and bill for urgent care services in accordance with s. 395.107 which measures at

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least 200 square feet must include the following statement in clearly legible contrasting color text at least 15 inches high: "(INSERT NAME OF HOSPITAL) EMERGENCY DEPARTMENT. THIS IS NOT AN URGENT CARE CENTER."

4.a. The agency shall post information on its website which provides a description of the differences between a freestanding emergency department and an urgent care center. Such description must include:

(I) At least two examples illustrating the impact on both insured and insurer paid amounts from the inappropriate use of nonemergent services and care in a hospital emergency department setting compared to the use of nonemergent services and care in an urgent care center;

(II) An interactive tool to locate local urgent care centers; and

(III) What to do in the event of a true emergency.

b. The agency shall update the information required in sub-subparagraph a. at least annually. Each hospital shall post a link to such information in a prominent location on its website.

5. A freestanding emergency department that provides and bills for urgent care services in accordance with s. 395.107 shall provide an emergency room billing acknowledgement form to a patient receiving emergency medical treatment from the emergency department after a medical screening examination is conducted and stabilizing care is provided to the patient. The form must have a heading that reads, "Your visit today will be billed as an emergency room visit" and must contain the following statement: "I, (insert patient's name), understand that today's visit will be BILLED AS AN EMERGENCY ROOM VISIT. I

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certify that the (insert hospital name) has not withheld, delayed, or conditioned a medical screening examination or stabilizing care based upon me signing or refusing to sign this form or based upon any payment related concerns. I understand that I may qualify for financial assistance if I am unable to pay for my care today."

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

And the title is amended as follows:

Delete lines 9 - 23

and insert:

out to the public as an urgent care center; providing an exception; requiring a freestanding emergency department to clearly identify itself as a hospital emergency department using certain signage; requiring a freestanding emergency department to post signs in certain locations which contain specified statements; providing requirements for such signs; providing requirements for the advertisement of freestanding emergency departments; requiring the Agency for Health Care Administration to post information on its website describing the differences between a freestanding emergency department and an urgent care center; requiring the agency to update such information on its website at least annually; requiring hospitals to post a link to such information on their websites; requiring certain freestanding emergency departments to provide an emergency room billing acknowledgement form to patients under certain circumstances;

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requiring that the form contain a specified heading and statement; amending

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 4/8/2021 9:01:18 AM
Ends: 4/8/2021 10:19:38 AM **Length: 01:18:21**

9:01:18 AM Sen. Bean (Chair)
9:03:29 AM S 414
9:03:32 AM Sen. Perry
9:04:16 AM Sen. Bean
9:04:26 AM Sen. Rouson
9:04:37 AM Sen. Perry
9:04:44 AM Sen. Bean
9:05:07 AM Michele Watson, CEO, Florida Children's Council
9:05:16 AM Sen. Bean
9:05:47 AM Sen. Rouson
9:06:25 AM Sen. Bean
9:06:29 AM Sen. Perry
9:06:56 AM Sen. Bean
9:07:00 AM Sen. Perry
9:07:05 AM Sen. Bean
9:07:58 AM Sen. Rodriguez (Chair)
9:08:03 AM S 606
9:08:13 AM Sen. Bean
9:09:52 AM Sen. Rodriguez
9:10:07 AM Michael Wickersheim, Director of Legislative Affairs, Florida Department of Children and Families (waives in support)
9:10:23 AM Sen. Harrell
9:11:14 AM Sen. Rodriguez
9:11:20 AM Sen. Bean
9:11:26 AM Sen. Rodriguez
9:11:57 AM S 1292
9:12:03 AM Sen. Bean
9:12:39 AM Sen. Rodriguez
9:12:50 AM Eric Prustman, Florida Association for Behavior Analysis (waives in support)
9:13:05 AM Beth Kidder, Deputy Secretary for Medicaid, Agency for Health Care Administration (waives in support)
9:13:58 AM Sen. Bean (Chair)
9:14:14 AM Sen. Book
9:14:16 AM S 1242
9:14:36 AM Sen. Bean
9:14:45 AM Sen. Book
9:15:10 AM Sen. Bean
9:15:45 AM Cliff Bauer, Vice President of Government Relations/President of Florida Pace Centers, Florida Pace Centers/ Miami Jewish Health (waives in support)*
9:15:48 AM Sen. Bean
9:16:07 AM Mark Hudson, Executive Director, Florida Pace Providers Association
9:16:37 AM Sen. Bean
9:16:45 AM Sen. Rouson
9:16:47 AM Sen. Bean
9:16:54 AM Sen. Rouson
9:17:32 AM M. Hudson
9:18:10 AM Sen. Bean
9:19:40 AM S 1976
9:19:45 AM Sen. Brodeur
9:20:06 AM Sen. Bean
9:20:15 AM Am. 880662
9:20:20 AM Sen. Brodeur
9:20:37 AM Sen. Bean

9:21:32 AM Sen. Brodeur
9:21:36 AM Sen. Bean
9:22:16 AM S 900
9:22:23 AM Sen. Rodriguez
9:23:08 AM Sen. Bean
9:23:23 AM Michael Wickersheim, Director of Legislatvie Affairs, Florida Department of Children and Families (waives in support)
9:23:58 AM Sen. Rodriguez
9:24:08 AM Sen. Bean
9:25:03 AM Sen. Rodriguez (Chair)
9:25:12 AM Sen. Diaz (Chair)
9:25:17 AM S 700
9:25:27 AM Sen. Rodriguez
9:26:05 AM Sen. Diaz
9:26:17 AM Am. 645592
9:26:27 AM Sen. Rodriguez
9:27:28 AM Sen. Diaz
9:27:44 AM Sen. Jones
9:27:58 AM Sen. Diaz
9:28:02 AM Sen. Jones
9:28:10 AM Sen. Rodriguez
9:28:14 AM Sen. Diaz
9:28:19 AM Sen. Harrell
9:28:28 AM Sen. Diaz
9:28:52 AM Am. 520292
9:29:02 AM Sen. Brodeur
9:29:38 AM Sen. Diaz
9:30:08 AM Sen. Brodeur
9:30:23 AM Sen. Diaz
9:30:26 AM Sen. Farmer
9:30:39 AM Sen. Diaz
9:30:41 AM Sen. Brodeur
9:31:26 AM Sen. Diaz
9:31:36 AM Joy M. Ryan, Lobbyist, Teladoc Inc. (waives in support)
9:32:10 AM Am. 607286
9:32:25 AM Sen. Rodriguez
9:33:22 AM Sen. Diaz
9:33:34 AM Sen. Farmer
9:33:45 AM Sen. Rodriguez
9:34:00 AM Sen. Diaz
9:34:03 AM Sen. Farmer
9:34:09 AM Sen. Diaz
9:34:11 AM Sen. Rodriguez
9:34:24 AM Sen. Diaz
9:34:31 AM Sen. Harrell
9:34:53 AM Sen. Diaz
9:34:57 AM Sen. Rodriguez
9:35:21 AM Sen. Diaz
9:35:23 AM Sen. Rodriguez
9:35:31 AM Sen. Diaz
9:35:33 AM Sen. Harrell
9:36:10 AM Sen. Diaz
9:36:12 AM Sen. Rodriguez
9:36:27 AM Sen. Harrell
9:36:52 AM Sen. Diaz
9:36:54 AM Sen. Rodriguez
9:37:07 AM Sen. Diaz
9:37:29 AM Jake Farmer, Director of Government Affairs, Florida Retail Federation
9:38:28 AM Sen. Diaz
9:38:51 AM Am. 867844
9:39:02 AM Sen. Rodriguez
9:39:15 AM Sen. Diaz

9:40:05 AM Sen. Harrell
9:40:28 AM Sen. Rodriguez
9:41:10 AM Sen. Diaz
9:41:13 AM Sen. Harrell
9:41:53 AM Sen. Diaz
9:41:55 AM Sen. Rodriguez
9:42:10 AM Sen. Diaz
9:42:20 AM Sen. Farmer
9:42:29 AM Sen. Diaz
9:42:33 AM Sen. Rodriguez
9:42:41 AM Sen. Farmer
9:42:51 AM Sen. Diaz
9:42:56 AM Sen. Rodriguez
9:43:09 AM Claudia Davant, Lobbyist, Florida Pharmacy Association (waives in support)
9:43:13 AM Michael Jackson, Executive Vice President & CEO, Florida Pharmacy Association (waives in support)
9:43:36 AM Ron Watson, Lobbyist, MUV Florida
9:45:35 AM Sen. Diaz
9:45:45 AM Sen. Farmer
9:46:04 AM R. Watson
9:46:42 AM Sen. Diaz
9:47:03 AM Sen. Farmer
9:47:10 AM Sen. Diaz
9:47:42 AM Sen. Farmer
9:47:59 AM Sen. Rodriguez
9:48:24 AM Sen. Diaz
9:48:39 AM Jodi James, Legislative Chair, Florida Cannabis Action Network
9:50:20 AM Sen. Diaz
9:50:39 AM Robert Fifer, Audiologist, FLASHA
9:52:30 AM Sen. Diaz
9:53:43 AM Diego Echevervi, Legislative Liaison, Americans For Prosperity (waives in support)
9:53:47 AM Jake Farmer, Director of Government Affairs, Florida Retail Federation (waives in support)
9:54:06 AM Theresa Bulger, Lobbyist, AGBell Association of DEAF (waives in support)
9:54:44 AM Chris Nuland, Florida Chapter, American College of Physicians (waives in support)
9:54:59 AM Sen. Diaz
9:55:01 AM Steve Winn, Executive Director, Florida Osteopathic Medical Association (waives in support)
9:55:09 AM Shane Messer, Government Affairs Director, Florida Council for Behavioral Healthcare (waives in support)
9:55:30 AM Janet Deig, Secretary, Self (waives in support)
9:55:33 AM Sen. Diaz
9:55:53 AM Elizabeth Deig, Self (waives in support)
9:56:03 AM Sen. Diaz
9:56:28 AM Danny Deig, Student, Children who are deaf
9:57:02 AM Sen. Diaz
9:57:10 AM Alexandria Deig, Professor/teacher, Parents of children who are deaf
9:57:46 AM Sen. Diaz
9:58:01 AM Jodi James, Legislative Chair, Florida Cannabis Action Network
9:58:26 AM Sen. Diaz
9:58:42 AM Sen. Jones
9:59:23 AM Sen. Diaz
9:59:30 AM Sen. Harrell
10:00:23 AM Sen. Diaz
10:00:28 AM Sen. Farmer
10:01:21 AM Sen. Diaz
10:01:49 AM Sen. Rodriguez
10:02:12 AM Sen. Diaz
10:02:48 AM Sen. Rodriguez (Chair)
10:02:52 AM S 894
10:03:00 AM Sen. Diaz
10:03:06 AM Am. 556138
10:04:40 AM Sen. Rodriguez
10:05:10 AM Sen. Jones
10:05:37 AM Sen. Rodriguez

10:06:02 AM Debra Cole, Physician Assistant, Florida Academy of Physician Assistants (waives in support)
10:06:11 AM Diego Echeverri, Legislative Liaison, Americans For Prosperity (waives in support)
10:06:37 AM James Zedaker, Physician Assistant, Florida Academy of Physician Assistants
10:10:03 AM Sen. Rodriguez
10:10:25 AM Sen. Farmer
10:10:29 AM Sen. Diaz
10:10:38 AM Sen. Rodriguez
10:10:41 AM Sen. Farmer
10:11:48 AM Sen. Diaz
10:13:34 AM Sen. Rodriguez
10:14:08 AM S 1142
10:14:17 AM Sen. Rodrigues
10:15:42 AM Sen. Rodriguez
10:15:45 AM Am. 266254
10:15:51 AM Sen. Rodrigues
10:16:00 AM Sen. Rodriguez
10:16:41 AM Steve Winn, Executive Director, Florida Osteopathic Medical Association (waives in support)
10:16:46 AM Alexandra Abboud, Government Affairs Liaison, Florida Dental Association (waives in support)
10:17:04 AM Chris Nuland, Florida Society of Plastic Surgery/ Florida Society of Dermatology
10:17:41 AM Sen. Rodriguez
10:17:44 AM Chris Lyon, Florida Association of Nurse Anesthetists (waives in opposition)
10:18:47 AM Sen. Farmer
10:18:58 AM Sen. Diaz
10:19:01 AM Sen. Rodriguez
10:19:04 AM Sen. Jones
10:19:10 AM Sen. Rodriguez
10:19:15 AM Sen. Diaz
10:19:25 AM Sen. Rodriguez
10:19:37 AM
10:19:38 AM