

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Harrell, Chair
Senator Berman, Vice Chair

MEETING DATE: Tuesday, October 15, 2019**TIME:** 9:00—10:30 a.m.**PLACE:** Pat Thomas Committee Room, 412 Knott Building**MEMBERS:** Senator Harrell, Chair; Senator Berman, Vice Chair; Senators Baxley, Bean, Book, Cruz, Diaz, Hooper, Mayfield, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Update on Children's Medical Services Program by Department of Health		Presented
2	Florida's Participation in the Interstate Medical Licensure Compact by the Office of Program Policy Analysis and Government Accountability		Presented
3	SB 58 Book (Compare H 177)	Prescription Drug Donation Repository Program; Designating the "Prescription Drug Donation Repository Program Act"; creating the program within the Department of Health; prohibiting donations to specific patients; requiring inspection of donated prescription drugs and supplies by a licensed pharmacist; prohibiting the sale of donated prescription drugs and supplies under the program; requiring the department or contractor to establish, maintain, and publish a registry of participating local repositories and available donated prescription drugs and supplies; authorizing the Governor to waive program patient eligibility requirements during a declared state of emergency, etc. HP 10/15/2019 Fav/CS AHS AP	Fav/CS Yeas 10 Nays 0
4	SB 100 Harrell (Compare H 57)	Dispensing Medicinal Drugs; Authorizing individuals licensed to prescribe medicinal drugs to dispense a 48-hour supply, rather than a 24-hour supply, of such drugs to any patient, including a discharged patient, under certain circumstances; authorizing such individuals to dispense a 72-hour supply if a state of emergency has been declared in the area, etc. HP 10/15/2019 Favorable AHS AP	Favorable Yeas 10 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Tuesday, October 15, 2019, 9:00—10:30 a.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	SB 230 Harrell (Compare H 221, S 218, S 226, S 390)	Department of Health; Requiring the Department of Health to develop strategies to maximize federal-state partnerships that provide incentives for physicians to practice in medically underserved or rural areas; revising licensure requirements for a person seeking licensure or certification as an osteopathic physician; extending through 2025 the Florida Center for Nursing's responsibility to study and issue an annual report on the implementation of nursing education programs; requiring dentists and certified registered dental hygienists to report in writing certain adverse incidents to the department within a specified timeframe; revising athletic trainer licensure requirements, etc. HP 10/15/2019 Fav/CS AP RC	Fav/CS Yeas 10 Nays 0

Other Related Meeting Documents

Children's Medical Services Health Plan



**Senate Committee on Health Policy
October 15, 2019**

**Cheryl Young, Director
Office of Children's Medical Services Managed
Care Plan & Specialty Programs**

CMS Health Plan 3.0



- CMS 1.0 (1970s to 2014) – Where we started
 - Direct services through specialty clinics
 - Care coordination to clinically eligible children Chronically Medical Complexity (CMC) with state health insurance
- CMS 2.0 (Aug 2014) – Launching into managed care
 - Florida Department of Health/CMS as a Managed Care Organization (MCO)
 - 62,000 CSHCN in Florida choose the CMS Health Plan
- CMS 3.0 (Feb 2019) – Improved delivery system for Children and Youth with Special Health Care Needs (CYSHCN), Improved administration and governance by DOH
 - CMS as a (MCO) with an improved delivery system for CMC/CSHCN
 - **69,322 CSHCN in Florida choose the CMS Health Plan (as of August 2019 compared to 63,378 one year ago)**

Children's Medical Services Health Plan Enrollment Increases

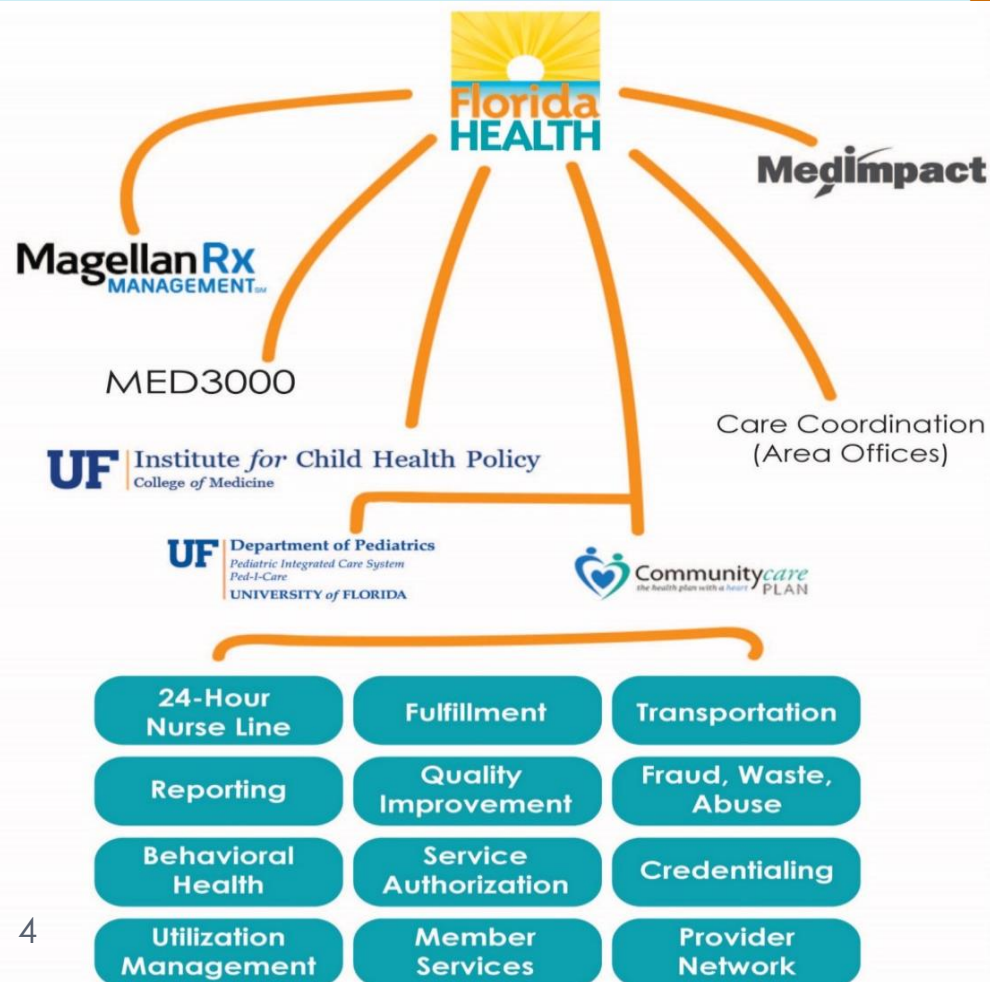


Membership in the CMS Plan pre- and post- improved model.
Marketing activities began June 2019.

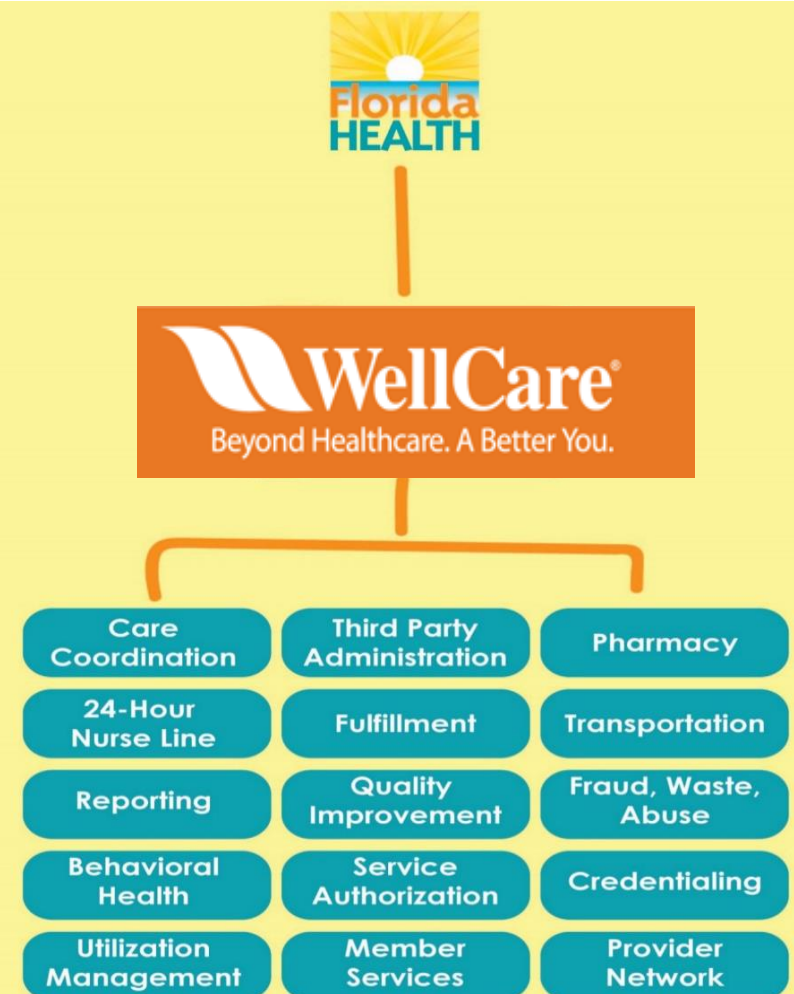
Enrollment Month	Title XIX (Medicaid)	Title XXI (KidCare)
July 2018	51,646	11,732
August 2018	51,983	11,864
September 2018	52,495	12,233
October 2018	52,963	12,368
November 2018	53,197	12,543
December 2018	53,427	12,596
January 2019	54,174	12,623
February 2019	54,182	12,731
March 2019	54,561	12,613
April 2019	54,656	12,537
May 2019	55,150	12,713
June 2019	55,527	12,843
July 2019	55,932	12,834
August 2019	56,418	12,905
September 2019	57,011	~12,975

**Nearly 70,000
Children and
Youth with Special
Health Care
Needs (CYSHCN)
in Florida choose
the CMS Plan,
compared to less
than 65,000 one
year ago**

Yesterday



Today



“Value-Based Care”



- Physicians and hospitals are paid for improving the health of patients with chronic illnesses and for keeping healthy patients healthy
- Process is evidence-based, data driven
- Similar term: “value-based purchasing”
- Designed around patients and quality
- Coordinated care

$$\text{Value} = \frac{\text{Quality}^*}{\text{Payment}^\dagger}$$

* A composite of patient outcomes, safety, and experiences

† The cost to all purchasers of purchasing care

Children's Medical Services Plan Transition Facts



- CMS employees hired by WellCare
 - UF/Ped-O-Care pediatric medical director
 - Other DOH CMS leaders
 - >130 CMS care coordinators hired by WellCare—still hiring to reach 500+ CMS dedicated team
- MD provider network with 92% overlap
 - 16,000 plus providers, 11,000 plus eligible for enhanced payment
 - Specialists as Primary Care Physicians (PCPs) also, required telemedicine
- 180 day “continuity of care” provision
- DOH Oversight and Governance

Children's Medical Services Plan

FOCUS ON FAMILIES



- Goals met for transition for families and providers
- “Warm hand-offs” for especially fragile children
 - Technology dependent
 - Skilled nursing facility, private duty nursing
 - Medical Foster Care (MFC)
 - Partners in Care: Together for Kids (PIC:TFK)
(Palliative Care)
- Regional and local office “transition” staff through June 2019
- Rapid issue resolution and partnership, ombudspersons and additional hotlines

Sample Family Info: New CMS Plan Model—*What Is Changing*

- Enhanced care coordination and better care coordination ratios
- Improved outcomes through physician payment
 - Quality outcomes
 - Mental/physical health
 - Telehealth
- In-lieu-of and expanded benefits for families



Children's Medical Services Plan Physician Incentive Program



As of June 2019:

- Physicians enrolled as CMS providers: 16,761
- Physicians enrolled as CMS providers qualifying for enhanced payments: 11,539
- Comments:
 - 11,539 qualifying for enhanced payments reflects the Managed Medical Assistance (MMA) Physician Incentive Program (MPIP).
 - WellCare is also in the process of developing additional physician incentive programs for the CMS Health Plan, most notably the “Partnership for Quality” (P4Q) program which is typically offered to 100% of PCPs with assigned members.

New Benefits for Families



Enhanced Benefits

- Housing assistance
- Caregivers behavioral health assistance
- Carpet cleaning
- Over-the-counter products
- Tutoring services
- Swimming lessons

In-lieu-of Benefits

- Emergency respite
- Equine, art and music therapies
- Mobile crisis assessment and intervention
- Crisis stabilization units
- Transition from skilled nursing facility to private home setting

Care Coordination: Quality Enhancements

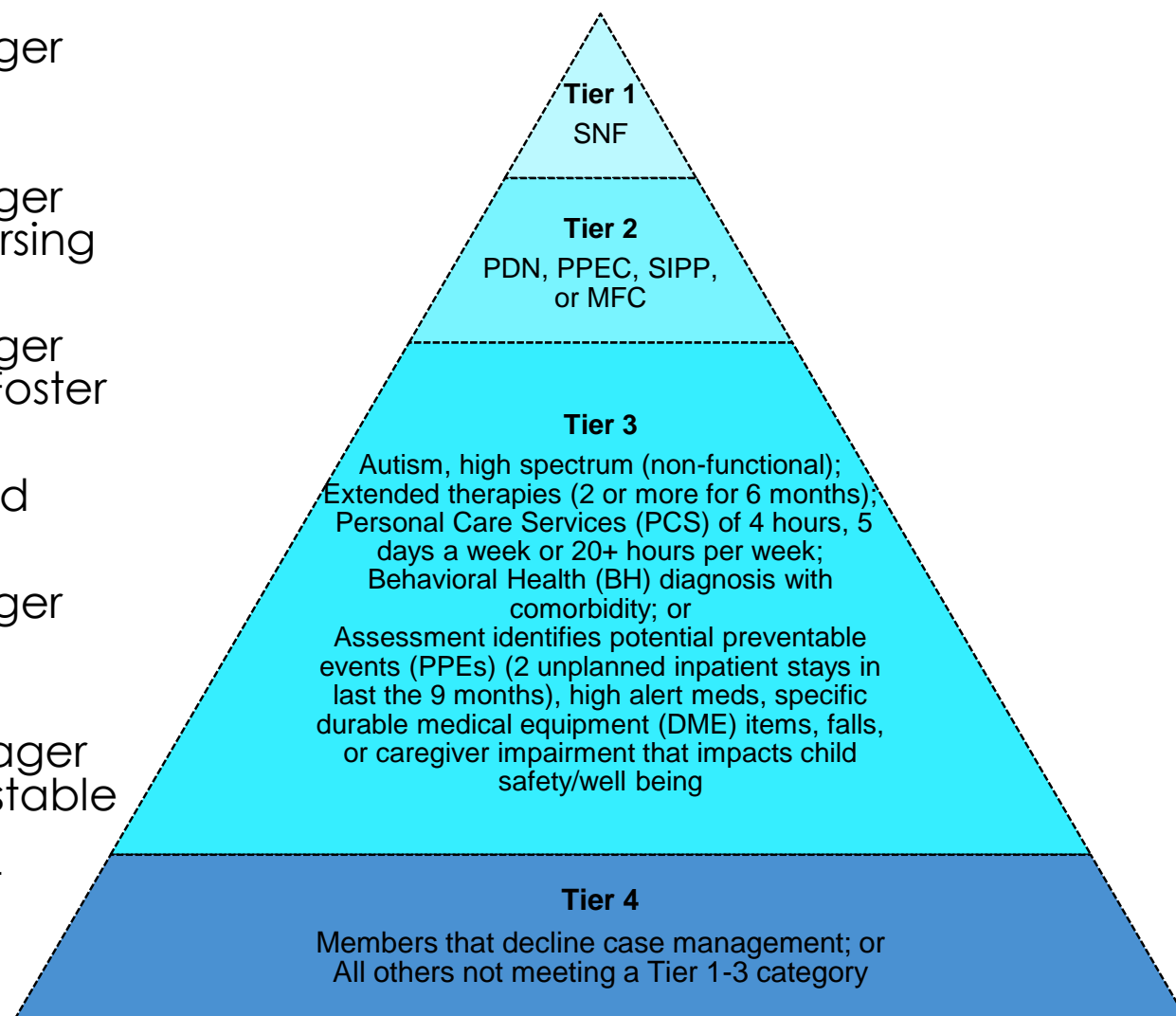
Health-related, community-based services offered and coordinated by WellCare, but not separately reimbursed include:

- A searchable database of community resources available to families and Care Coordinators/Care Managers
- Screens for signs of domestic violence and referral services
- Pregnancy prevention programs for adolescents
- Agreements with local Healthy Start Coalitions
- Nutritional assessment and counseling to all pregnant and postpartum enrollees and their children
- Outreach to enrollees in and at risk of juvenile justice system involvement

Care Management

Caseload/Staffing Ratios

- 15 members to one care manager for children residing in nursing facilities
- 40 members to one care manager for children with private duty nursing in the community
- 40 members to one care manager for children within the Medical Foster Care Program
- Care Plan must be reviewed and signed by Medical Director
- 90 members to one care manager for children stratified as high/moderate risk
- 200 members to one care manager for those whose conditions are stable or who are in a care monitoring status within care management



Children's Medical Services Plan Care Management



Case Management	Tier 1	Tier 2	Tier 3	Tier 4
Acuity	High	Medium	Low	Disease Management
Caseload Max per Care Manager	15	40	90	200
Face-to-Face	2/month	1/month	1/quarter	
Telephone contacts	2/month	1/month	1/month	1/quarter
Plan of Care Review	1/month	1/month	1/month	1/year
Plan of Care Update	3 months (quarterly)	6 months (semiannually)	6 months (semiannually)	12 months (annually)
Multidisciplinary Team (MDT) Meetings	6 months (semiannually)	6 months (semiannually)	As needed	As needed
Reassessment	12 months (annually)	12 months (annually)	12 months (annually)	12 months (annually)
Quality of Life Survey	Initially, Annually	Initially, Annually	Initially, Annually	Initially, Annually

Care Coordination / Care Management Overview – Special Programs



Building out specialized programs and initiatives for children with special needs and their families

Child-Focused Programs and Initiatives

Early Steps

Dedicated to assisting the ~4,400 current CMS members 0-3 years

WellCare at School

Dedicated to assisting the ~49,000 current school-age CMS children and youth

Transition Milestones

Dedicated to assisting the ~25,000 current CMS youth who are 12 years of age or older

Community Connections

Information and referrals for children and caregivers through CAL and QE database

Consumer and Provider Advisory Committees Allow us to gather children- and family-centered insights and experience from children, families and caregivers, providers, community-based organizations, and advocates.

Leveraging WellCare at Home fully integrated care model



- Ensures children and families are active, core partners in decision making
- Deliver services and supports in a culturally competent, linguistically appropriate, and accessible manner
- Access to affordable, comprehensive, and continuous care
- Facilitate access to evidence-based (or evidence-informed)
- Address physical, behavioral health, pharmacy, and social support needs of children and families across settings
- Features integrated, multi-disciplinary, regionally-based Care Management Teams (co-located where children and families reside)
- Specialized roles
- Person and family-centered care planning
- Fully integrated clinical platform
- Regionally-based *Welcome Rooms*
- Pharmacist-performed medication reconciliation

Quality Improvement: Performance Measures



Total of 42 Performance Measures across various domains including 10 new proposed Child Health measures. The ten new measures include:

ED visits per
1,000 member
months

Percentage of
children ages 10–17
months receiving a
developmental
screening

Rate of
hospitalization for
non-fatal injury per
100,000 children ages
0–9 and adolescents
10–19

Percentage of
adolescents with a
preventive medical
visit in the past year

Adolescent
Screening for
Depression

New enrollees provided initial health
assessment within 30 days and completed
person-centered plan within 45 days of
enrollment

Use of PCMHs

Proportion of children
receiving services in
a medical home

Percentage of youth
reporting transition in
place

Quality of Life Survey
results reported

CMS Plan/Specialty Programs Vision



Every child with special health care needs (esp. CMC) has **access to high-quality, evidence-based, family-centered medical care, regardless of health insurance.**

- Appropriate quality measures (health plan, programs)
- Regional Networks for Access and Quality (R-NAQs) and Statewide Networks for Access & Quality (S-NAQs)
 - Essential infrastructure for quality improvement, team-based care
 - Health and well-being of ALL children – because CYSHCN are especially vulnerable to their environment
 - Community partnerships and other state programs

CMS Health Plan – Option of choice for families/CMC

Questions/For more information:



www.CMSPlanFlorida.gov

Director, Office of CMS Plan

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Division of Children's Medical Services



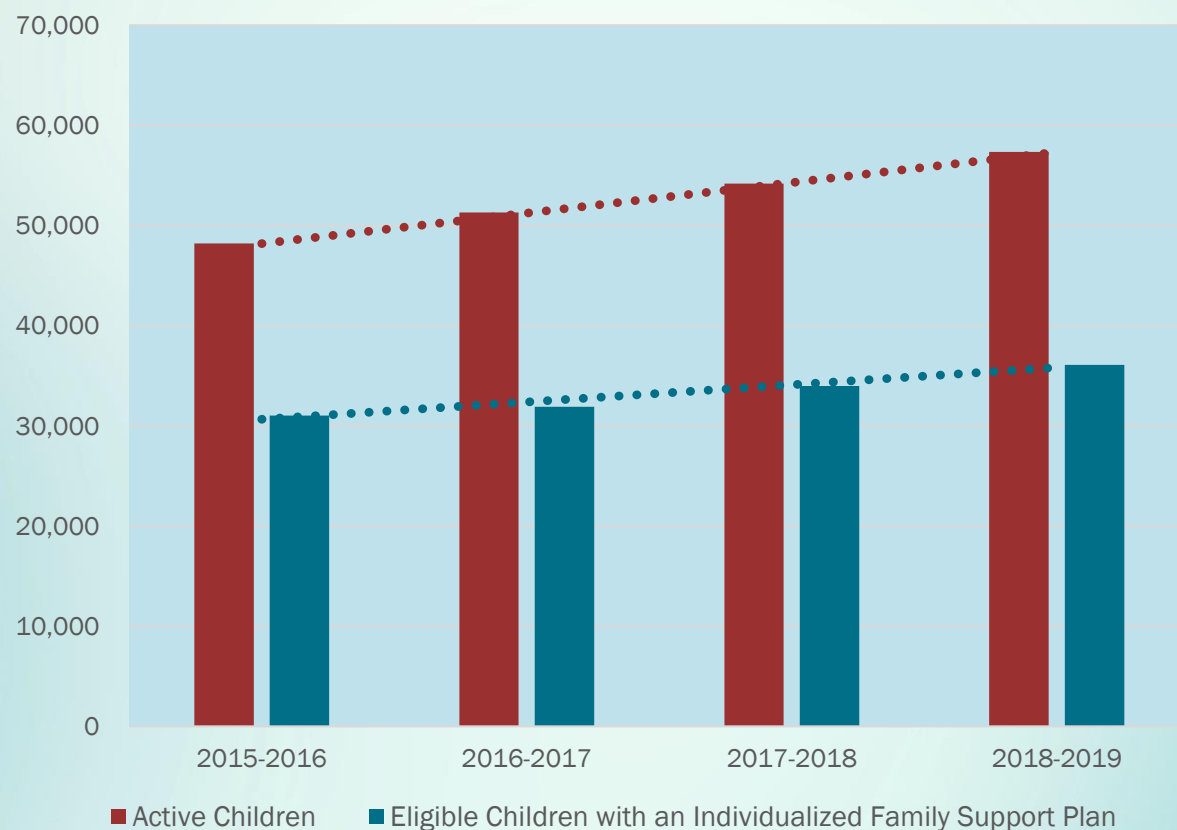
**Senate Committee on Health Policy
October 15, 2019**

**Cassandra G. Pasley, BSN, JD, Director
Division of Children's Medical Services
Early Steps Program**

Early Steps Eligibility

Eligibility	
Age	Children birth to 36 months
Developmental Delay; OR	Children who do not meet developmental milestones at expected times in one or more of the following areas: cognitive, motor, communication, social/emotional, or adaptive/self help
Established Condition; OR	Children with conditions known to cause developmental delays, such as: Down Syndrome, Cerebral Palsy, or Spina Bifida
At-risk Condition	Children with conditions that have a high likelihood of causing a delay, such as: Traumatic Brain Injury, Neonatal Abstinence Syndrome, and Low Birth Weight

Number of Children Served



*Active children are those for whom action was taken at some point during the fiscal year, including those eligible with an IFSP, referred and found not eligible, and those yet to complete the eligibility determination process.

**An IFSP is an Individualized Family Support Plan developed by the Local Early Steps evaluation team and the child's family after eligibility determination.

Early Steps Services

December 1, 2018;
January 1, 2019;
February 1, 2019
Services
Transitioned into
Managed Care

- Developmental Evaluations
- Developmental Screenings
- Targeted Case Management
- Early Intervention Sessions
- Assistive Technology Devices and Services
- Audiology
- Health and Medical Services
- Nursing
- Nutrition
- Occupational, Physical, and Speech Therapies
- Psychological Services
- Social Work
- Hearing and Vision Services

August 2014
Services
Transitioned into
Managed Care

Transition Priorities

- Services to children are not disrupted.
- Providers are paid.
- All Florida programs and providers remain in compliance with:
 - State laws.
 - Individuals with Disabilities Education Act (IDEA), Part C, and
 - Medicaid rules and regulations.

Transition Activities

- Claims
 - Provided technical assistance to Local Early Steps (LES) to address barriers to successful claims submission and payment, including linking existing Early Steps Data System to a claims processing clearinghouse.
 - Contracted with experienced-billing organization to provide support to LES and provided additional billing personnel to LES through a staffing agency.
 - The Agency for Health Care Administration (AHCA) initiated an expedited complaint resolution process and extended the Continuity of Care period.
- Technical Assistance
 - Federal technical assistance center provided resources on other states implementation of Managed Care.
 - Created a specialized team at the Department of Health to provide targeted technical assistance to LES.

Transition Activities (continued)

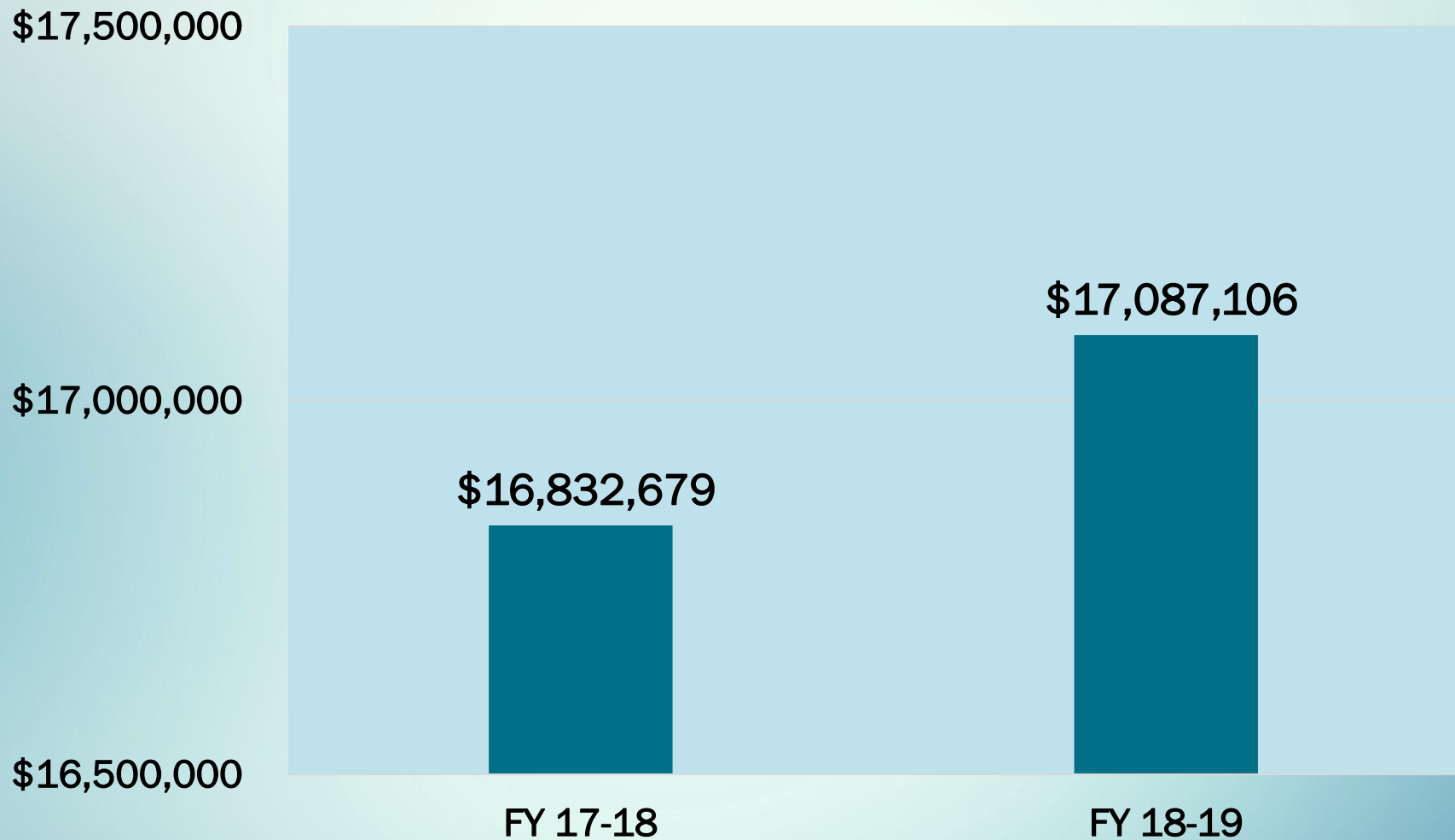
- Communication
 - Routine conference calls to identify and address any challenges during the transition and shared best practices.
 - In-person and web-based meetings including the Department of Health, AHCA, LES, community providers, and Managed Medical Assistance (MMA) Plans.
 - Updated the Florida Interagency Coordinating Council for Infants and Toddlers and received feedback.

Timely Eligibility Requirement

- Children referred to Early Steps must receive an initial evaluation, assessment, and Individualized Family Support Plan within 45 days of being referred (34 CFR §303.310 (a)).

	1/2018 - 6/2018	1/2019 - 6/2019
Eligible Infants and Toddlers Receive an Individualized Support Plan within 45 days of referral	88.7%	89.8%

Medicaid Early Intervention Services Payment to Providers



Lessons Learned

- Communication and coordination with partners is critical to ensure a holistic approach for integrated service delivery.
 - Early intervention providers have a unique set of skills and expertise; therefore, MMA Plans require LES providers to strengthen their provider networks.
 - LES continue to work with MMA Plans to ensure providers are paid for services rendered, which ensures compliance with the IDEA, Part C payor of last resort requirement.

Next Steps

- AHCA, in partnership with the Department of Health, is initiating a stakeholder group that includes providers and health plans to implement program enhancements based on lessons learned during the transition.
- Continue to ensure children are served, providers are paid, and programs remain in compliance with laws, rules, regulations, and policies.

THE FLORIDA SENATE

APPEARANCE RECORD

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

10/15

Meeting Date

Tab 1

Bill Number (if applicable)

Topic

Amendment Barcode (if applicable)

Name Cheryl Yound

Job Title Director, CMS Health Plan / Specialty Programs

Address

Phone

Street

City

State

Zip

Email

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Dept of Health - Childrens Medical Svs

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

10/15/19
Meeting Date

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

Tabl
Bill Number (if applicable)

Topic Federal Title IV-E Waiver Funding Update
Amendment Barcode (if applicable)

Name VICTORIA ZEPPE

Job Title Chief Policy Officer

Address 411 E. College Ave
Street

Phone

TH
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32301
State Zip

Email

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FL COALITION for CHILDREN

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts

A Presentation to the Senate Committee on Health Policy

Tina Young, Senior Legislative Analyst
Janet Tashner, General Counsel



OPPAGA

Office of Program Policy Analysis and Government Accountability

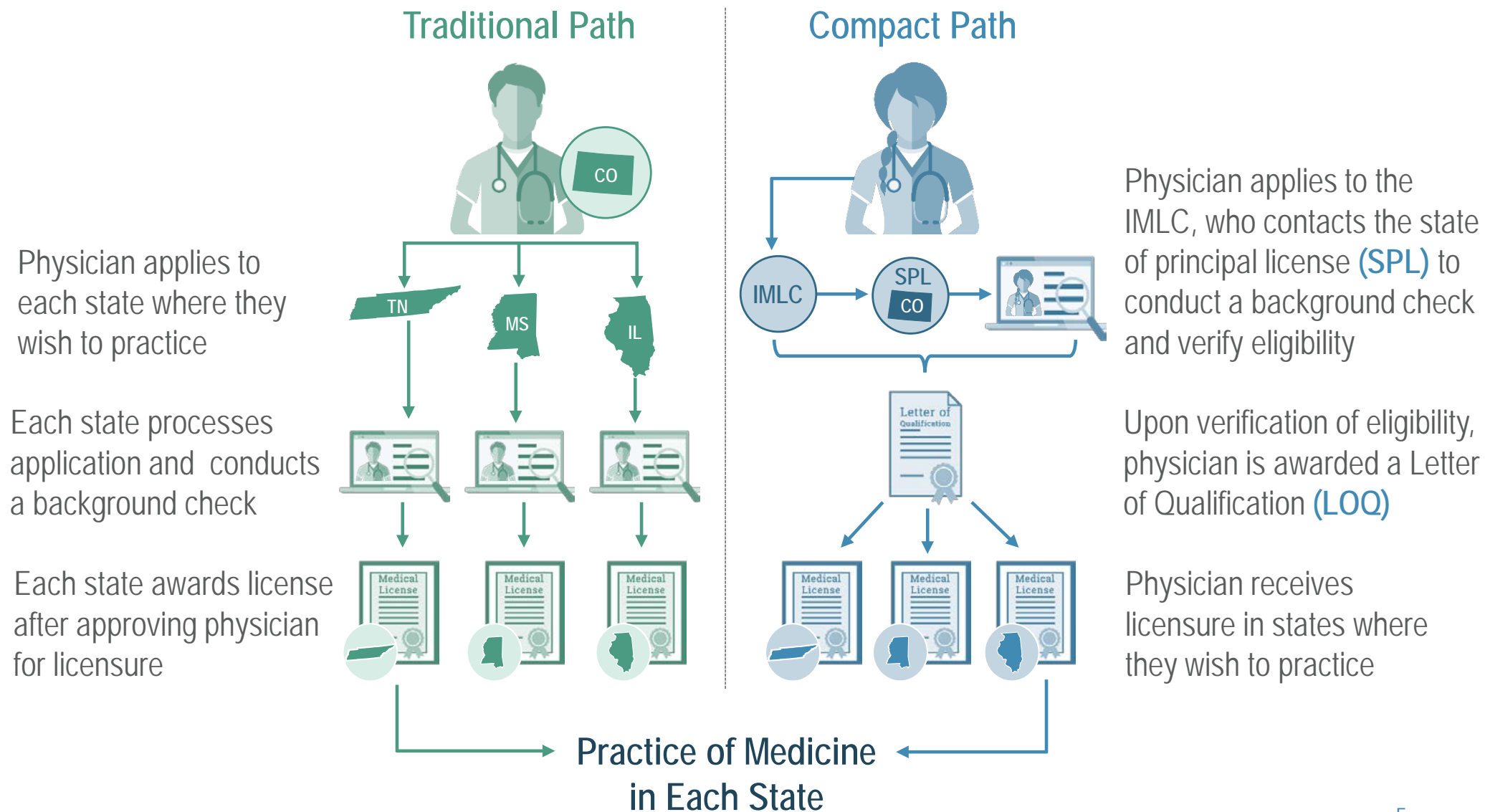
OCTOBER 15, 2019

Overview















- 1 Background
- 2 Implications of Compact Membership for Florida
- 3 Conflicts Between Compact Provisions and Florida's General Laws and Constitution

Background

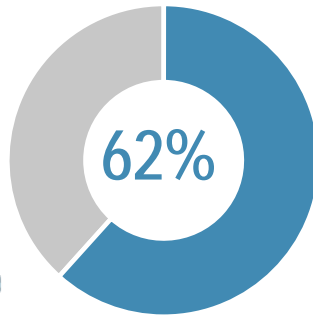
How Does The Compact Process Differ From The Traditional Licensure Process?



How Do Florida Licensure Requirements Compare to Compact Eligibility Requirements?

Licensure Qualification	Florida Licensure Criteria	Compact Eligibility Criteria
Graduated from an accredited medical school		
Passed applicable medical examinations		
Specialty board certification		
No history of disciplinary actions		
No criminal history		
No history of controlled substance actions toward licenses		
Not under investigation		
Not on U.S. HHS's List of Excluded Individuals and Entities		

What Options Exist for Out-of-State Physicians to Practice in Florida?



The majority of physicians who applied to practice medicine in Florida during FY 2018-19 were from out-of-state

Current Options to Practice in Florida

The compact would provide another option for these physicians to provide healthcare services in Florida

1 | Licensure in Lieu of Examination

- Full license granted
- In-person or telemedicine

Practice in Florida

2 | Telehealth Registration

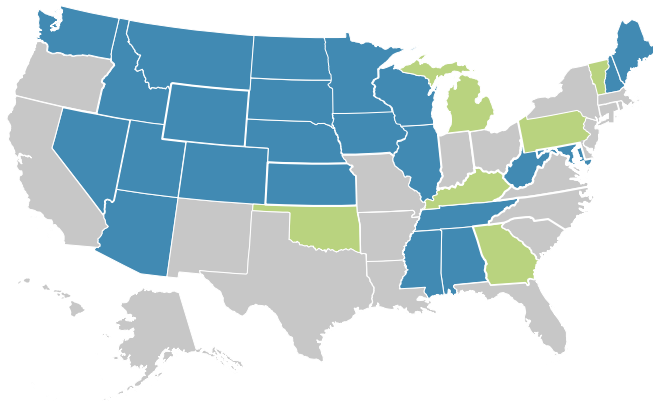
- No license granted
- Telemedicine
- Practice in Florida

3 | License via Compact

- Full license granted
- In-person or telemedicine

Practice in Florida and any other state(s) where physician holds a license via the compact

What Did Compact Member States Say About Their Experience?



23

Compact states are active members and processing licenses

8

Member boards are in the process of implementation

OPPAGA received info from 15 boards

Benefits

- Increase the supply of physicians (including specialists)
- Expedited process for issuing licenses

Preparation

- Training of licensing staff
- Adjusting internal databases
- Adjusting fiscal processes to manage collection of fees

Legal Issues

- Primary legal issue related to the ability to process FBI background checks for physicians

Implications of Compact Membership for Florida

Compact Member States Retain Control Over Several Licensure-Related Activities

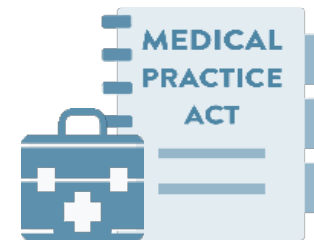
Determine Eligibility of Compact Applicants



Issue Licenses to Out-of-State Physicians



Regulate the Practice of Medicine



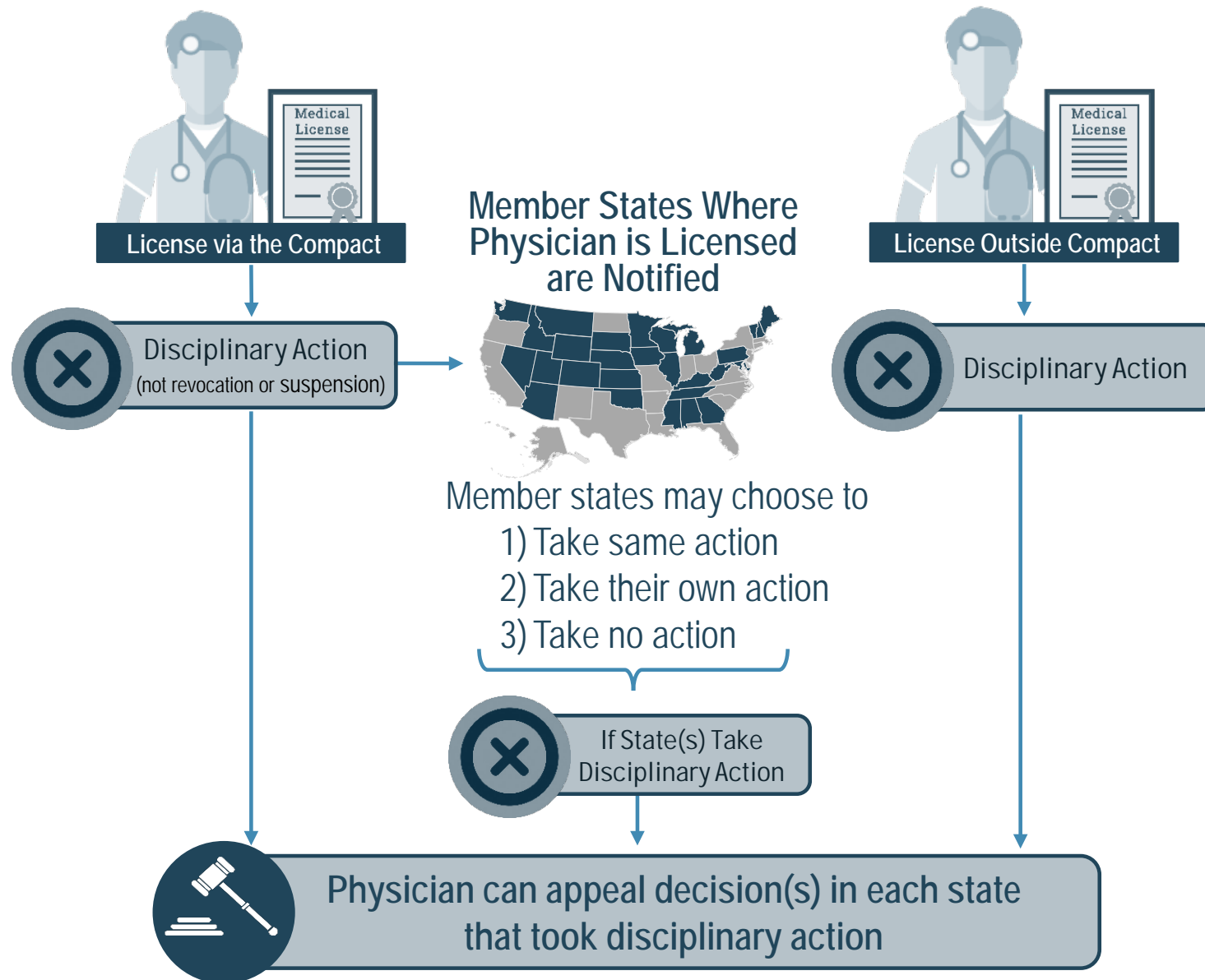
Control License Renewal Standards and Processes



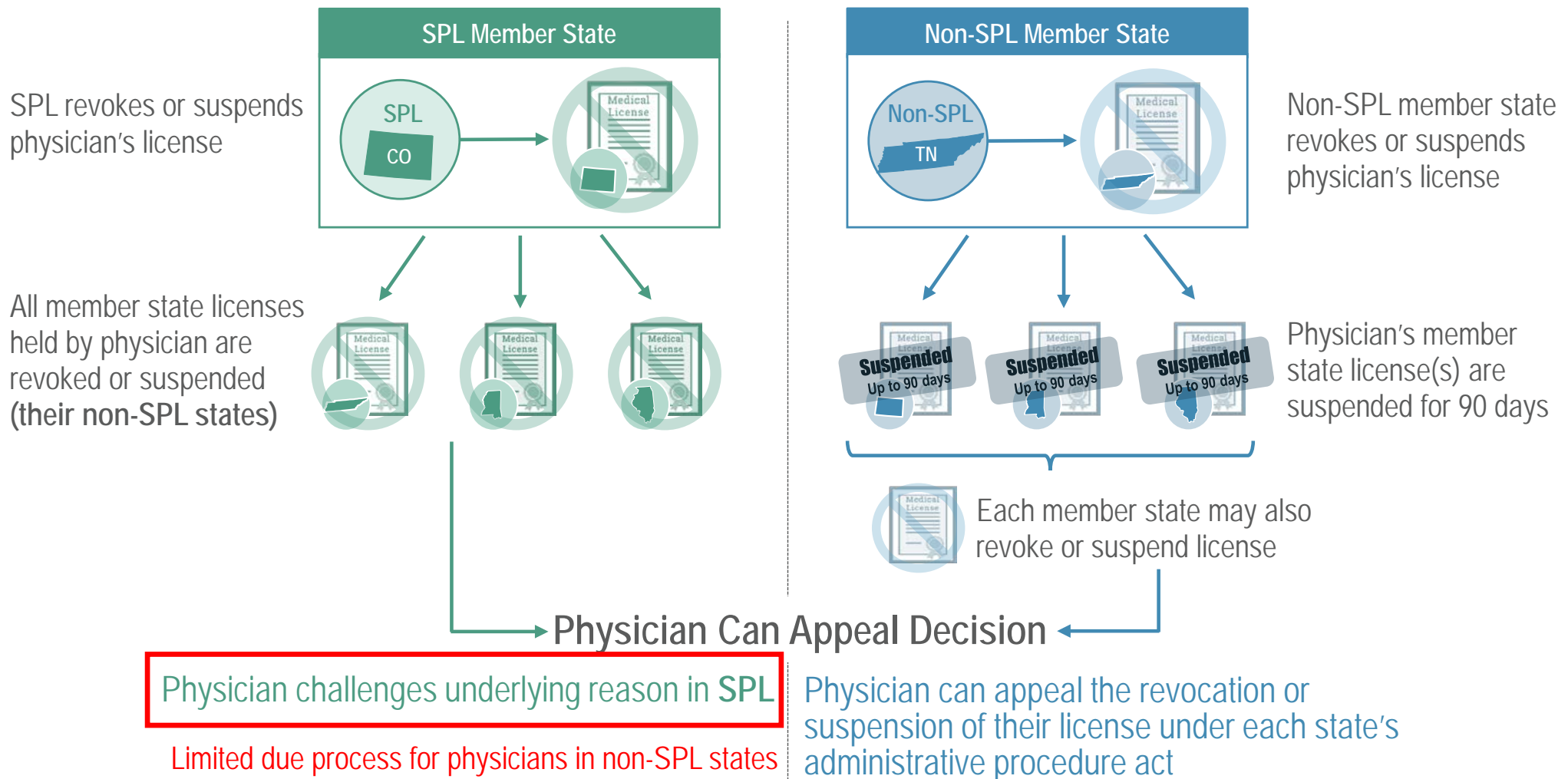
Retain Control Over Discipline



How Would Florida Compact Membership Affect Discipline (Other than Revocation or Suspension)?



How Would Florida Compact Membership Affect License Revocation or Suspension?



Conflicts Between Compact Provisions and Florida's General Laws and Constitution

Licensure Qualifications

Conflict

Florida has a licensure requirement with no comparable compact eligibility requirement; however Florida would still have to issue an unencumbered license to compact physicians even if they do not meet this requirement

Florida will not issue a license to someone who is on the U.S. Department of Health and Human Services' [List of Excluded Individuals and Entities](#)

Criminal offenses
(covered by compact)

Non-criminal offenses
(not covered by compact)



Florida would be required to waive this eligibility criteria and issue a license to the applicant

Option

The Legislature could consider repealing one or more of Florida's licensure provisions that fall outside of the compact's licensure requirements

Due Process

Conflict

While Florida physicians whose SPL is designated in Florida would have full due process rights in Florida, those who designate an SPL other than Florida would have more limited due process rights

- Physicians can challenge underlying reasons for suspension or revocation of their medical license **only in their SPL**



Florida as a compact member state would be required to adopt an SPL revocation or suspension determination without providing the physician with due process in Florida for the underlying reasons for suspension or revocation

Option

The Legislature could consider statutory changes to Ch. 456, *Florida Statutes*, to provide physicians in these circumstances with the opportunity to challenge the underlying reason for revocation or suspension

Commission Meetings

Conflict

The compact commission may have closed meetings under certain circumstances; this conflicts with Florida's Constitution and Sunshine Law

- Compact law allows commission members to close a meeting when two-thirds of the commission votes that it would meet certain conditions



Under the Florida Constitution and Sunshine law, the public is entitled to notice of and access to government meetings as well as to copy and inspect meeting records

Option

The Legislature may consider adopting exemption language similar to that provided to the Nurse Licensure Compact to address conflicts with existing public meetings requirements

Sovereign Immunity

Conflict

Compact bylaws provide the commission with immunity from suit and liability, while Florida allows suit to be brought against the state



By adoption of the compact, Florida would afford the commission immunity and the same limited protections from criminal prosecution and civil suits as the state of Florida affords itself and its employees

Option

The Legislature may consider adding tort limitation language, as they did when joining the Nurse Licensure Compact, clarifying that the compact will pay any claims or judgments arising from commission employees' employment-related actions in the state

Public Records

Conflict

For physicians who designate another state as their SPL, Florida would not have access to physician records, which conflicts with public records laws

- Under the compact, only the state of primary licensure and the commission receive the underlying documents associated with a letter of qualification



If Florida adopts the compact language, it would be creating a de facto records exemption for those records in the hands of the compact, whereas the records would typically be subject to Florida's public record laws

Options

- 1 The Legislature could adopt a statutory exemption protecting these records from public disclosure
- 2 The Legislature could require that physicians licensed through the compact provide Florida with copies of all documents provided to the SPL and compact as one of the criteria for practicing medicine in Florida via Ch. 456, *Florida Statutes*

Summary of Options to Consider

Consideration	Option
Infrastructure	Work with the Department of Health to set a compact implementation date to ensure that the department would have adequate time to make required changes to rule, forms, and technological infrastructure in order to process licenses through the compact.
Licensure Qualifications	Repeal one or more of Florida's initial licensure provisions that fall outside of the compact's licensure requirements by amending Ch. 456 , <i>F.S.</i>
Due Process	Enact statutory language providing physicians who practice in Florida and had their license revoked in their state of primary licensure an opportunity to challenge that revocation or suspension in Florida.
Meetings	Enact statutory language providing an exemption allowing closed meetings.
Sovereign Immunity	Enact statutory language clarifying that the compact pays any claims or judgments arising from the commission's employment-related actions in the state by amending s. 768.28 , <i>F.S.</i>
Public Records	Enact statutory language providing an exemption allowing records received by the commission as exempt from disclosure. Provide a statutory exemption for application records by amending Ch. 456 , <i>F.S.</i>

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FLORIDA LEGISLATURE OFFICE OF PROGRAM POLICY ANALYSIS AND
GOVERNMENT ACCOUNTABILITY

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations.

Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts

Report No. 19-07

Date: October 1, 2019



OPPAGA

Office of Program Policy Analysis and Government Accountability

Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts

EXECUTIVE SUMMARY

The compact provides an expedited process for physicians to seek licenses in multiple states. The Interstate Medical Licensure Compact is an agreement among member states whereby physicians can voluntarily seek medical licensure in an expedited manner. Twenty-nine states, the District of Columbia, and the Territory of Guam are members of the compact.

As a compact member, Florida would retain the right to regulate the practice of medicine, but some of the state's licensure provisions fall outside of compact requirements. Florida would have the option to participate in joint disciplinary investigations and would continue to resolve disciplinary actions pursuant to Florida's medical practice acts. License suspension and revocation actions by other compact states would require Florida to take action based on another state's determination. While Florida compact physicians would have due process rights in Florida, these rights would be more limited if a Florida physician chose to designate a state other than Florida as their state of principal license under the compact.

Legal conflicts between compact provisions and Florida's general laws and constitution would need to be addressed statutorily if the state decided to join.

If Florida joined the compact, it would enter into a formal agreement that binds the state to the compact's provisions through statute. However, since some of these provisions conflict with Florida's laws and require stand-alone bills, the Legislature would need to consider statutory changes if the state wished to join the compact. The Legislature could consider addressing general licensing requirements, due process procedures, sovereign immunity, closed meetings, and public records by enacting statutory exemptions or making other statutory changes.

REPORT SCOPE

Chapter 2019-138, *Laws of Florida*, directs OPPAGA to analyze the Interstate Medical Licensure Compact and relevant statutory and constitutional requirements and develop recommendations addressing Florida's prospective entrance into the compact. The report answers six questions.

- What is the Interstate Medical Licensure Compact?
- How does medical licensure work under the compact?
- What do other states report about their experiences with the compact?
- How does medical licensure currently work in Florida?
- How would compact membership affect medical licensure and disciplinary processes in Florida?
- What compact provisions appear to conflict with the state's general laws and constitution and what actions could the Legislature take to resolve such conflicts?

In 2015, representatives from individual state medical boards in conjunction with the Federation of State Medical Boards created the compact to provide an avenue for licensure in multiple states without the nationalization of the practice of medicine. Under this process, state medical boards that are members of the compact issue licenses to out-of-state physicians seeking licensure in their state in an expedited fashion, as well as certify that physicians in their state are eligible to seek licensure elsewhere under the compact. States that initially joined the compact have been issuing licenses under this process since 2017.³

The compact is governed by the Interstate Medical Licensure Compact Commission (the commission), which is comprised of two voting representatives from member states' medical boards who serve as commissioners.⁴ The commission serves as the administrative body for the compact. It holds regular meetings and promulgates rules that apply to the compact's expedited licensure process and to the physicians who seek licensure through the compact.

How Does Medical Licensure Work Under the Compact?

Physicians who practice medicine or osteopathic medicine may choose to seek licensure in multiple states through the compact process if they meet certain eligibility requirements, which were developed to exceed physician requirements of state medical boards. (See Exhibit 2.) The compact estimates that 80% of physicians nationally meet the criteria for licensure through the compact. A Florida stakeholder group has expressed interest in joining the compact because these eligibility requirements would ensure that high-quality physicians have easier access to seek licensure in the state. In almost all instances, these compact eligibility requirements are substantively similar to or exceed Florida's licensing requirements. (See Appendix A for more information.)

The compact provides a centralized eligibility verification process for multistate medical licensure that differs from the traditional path to multistate licensure. Typically, a physician would be required to apply separately to each state in which he or she wished to practice medicine, and each state would verify the physician's qualifications in order to issue a license. Under the compact's processes, however, a physician's full eligibility verification is conducted one time by the physician's state of principal license (SPL). Each physician who wishes to use the compact licensure process must

Exhibit 2 Compact Eligibility Criteria

1. Holds a full, unrestricted medical license in a compact member state
2. Graduated from an accredited medical school, or a school listed in the International Medical Education Directory
3. Successfully completed the Accreditation Council for Graduate Medical Education or American Osteopathic Association accredited graduate medical education
4. Passed each component of the U.S. Medical Licensing Examination®, Comprehensive Osteopathic Medical Licensing Examination of the U.S., or equivalent in no more than three attempts
5. Holds a current specialty certification or time-unlimited certification by the American Board of Medical Specialties or American Osteopathic Association Bureau of Osteopathic Specialists
6. Does not have any history of disciplinary actions towards their medical license
7. Does not have any criminal history
8. Does not have any history of controlled substance actions toward their license
9. Is not currently under investigation

Source: Compact law.

³ The states that joined the compact in its first year of operation, 2015, were Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, and Wyoming.

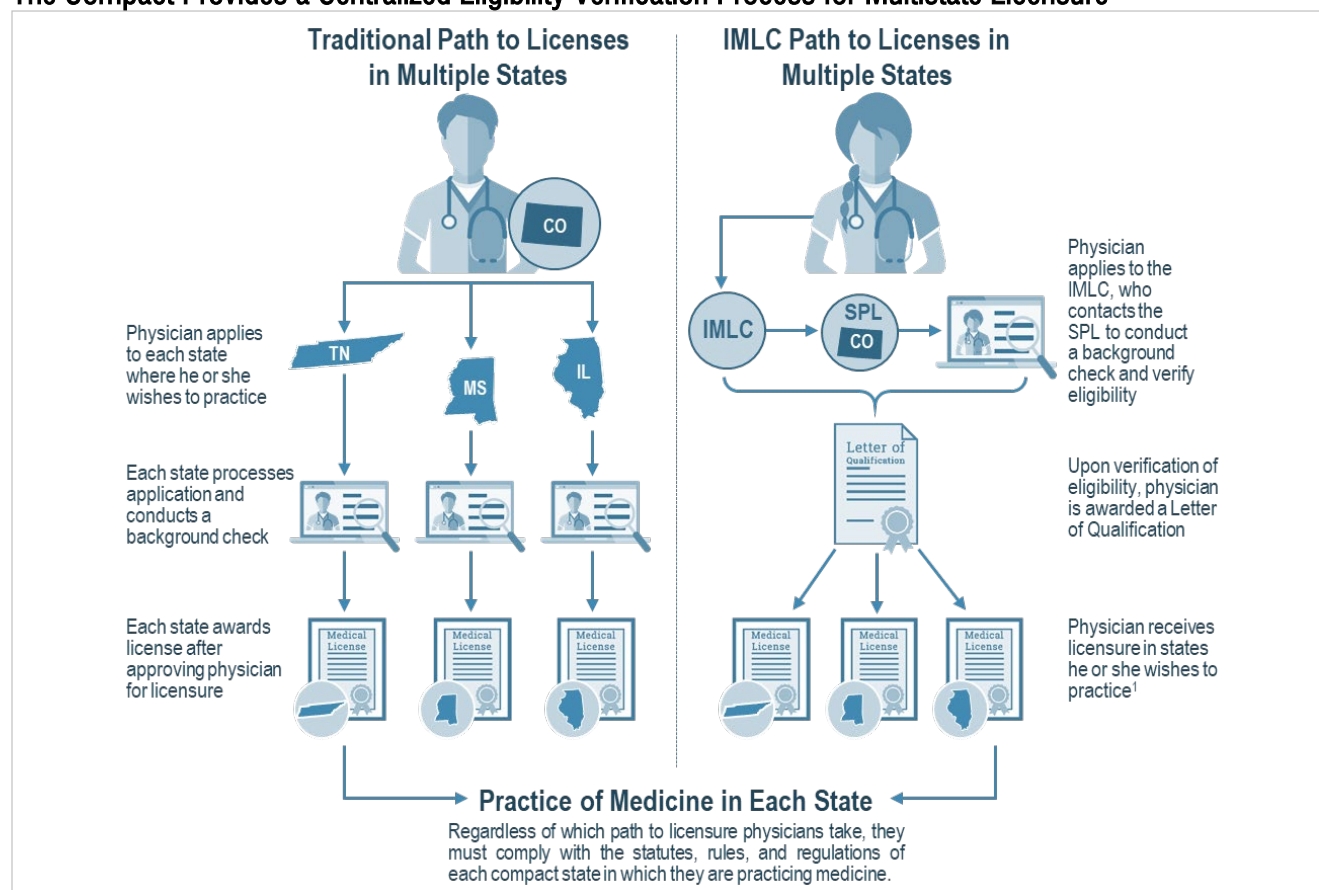
⁴ In states where separate member boards regulate allopathic and osteopathic physicians, the member state appoints one representative from each member board.

designate an SPL, which is considered the physician's primary place of practice.⁵ Subsequently, the physician may apply for licenses in other compact states without the need for those states to complete the entire verification process again.

The process begins when a physician submits an online application, a completed fingerprint packet or other biometric data check sample, and a sworn statement attesting to the truthfulness and accuracy of all information provided to their SPL. The physician must also pay a non-refundable \$700 fee to the commission, which then remits \$300 of that fee to the member board to determine a physician's eligibility to apply for licensure via the compact. The SPL collects and reviews all of the physician's source documents to ensure that he or she meets the compact's eligibility criteria and conducts an FBI background check.⁶ Upon verification of the physician's eligibility, the SPL issues a letter of qualification (LOQ) to the physician, which is valid for 365 days. During this time, the physician may seek licensure in other member states by presenting their LOQ to each state in which they wish to practice and paying a \$100 service fee in addition to each state's individual licensing fees. (See Exhibit 3.)

Exhibit 3

The Compact Provides a Centralized Eligibility Verification Process for Multistate Licensure



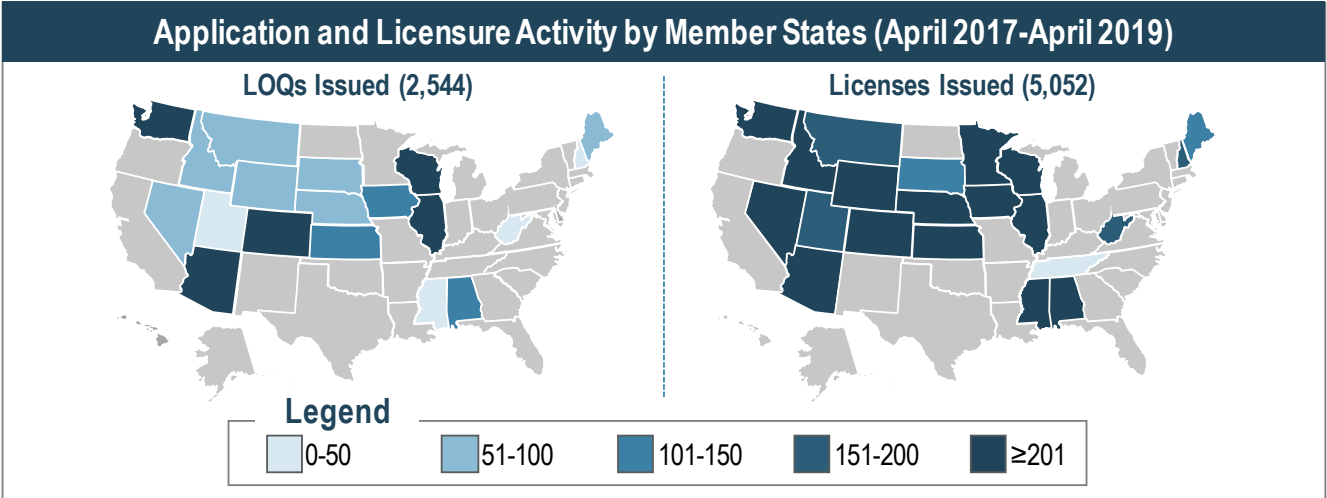
¹ The physician is responsible for paying the licensing fees of the states in which he or she is seeking a license.
Source: OPPAGA analysis of the compact application process.

⁵ A physician can designate a member state as their SPL if the physician possesses a full and unrestricted license in that state, and if the state fits within one of the following criteria: (1) the SPL is the physician's primary residence; (2) at least 25% of the physician's practice occurs in the SPL; (3) the physician's employer is located in the SPL; or (4) the physician uses the SPL as their state of residence for U.S. federal income tax purposes.

⁶ If the physician is deemed ineligible to apply for licensure through the compact's expedited process, they may still seek licensure in every state in which they desire to practice through the traditional paths to licensure established in other states.

Compact member states began issuing LOQs and medical licenses through the compact in April 2017. Commission staff reported there were 2,544 LOQs and 5,052 licenses issued from April 2017 through April 2019. During this time, the highest volumes of LOQs were issued in Colorado, Illinois, and Wisconsin, and the highest volumes of licenses were issued in Arizona, Minnesota, and Wisconsin.⁷ Most member states during this period issued more licenses to incoming physicians than LOQs to their own states' physicians, suggesting that participation in the compact may be helping some member states address physician shortages. (See Exhibit 4.)

Exhibit 4
From April 2017 Through April 2019, Most Member States Issued More Licenses for Incoming Physicians Than Letters of Qualification to Their Own Physicians



Source: Compact review of completed applications received from April 2017 through April 2019.

The average time it takes to receive a license under the compact is higher than Florida's average time to receive a license. Although the compact does not impose a minimum timeframe for member boards to issue an LOQ or grant a license to a physician, the commission estimates that it takes an average of 19 days from the time an SPL verifies eligibility to the date licenses are granted, with 51% of the licenses being issued in 7 days or less.⁸ This average is slightly longer than the processing time for a physician to receive a Florida license, and it does not take into account the time it takes to receive an LOQ. However, the compact licensing time could potentially result in the issuance of multiple licenses for a physician, while the Florida process only allows for a Florida license. (See Exhibit 5.)

Exhibit 5
While The Average Time to Receive a License Via the Compact Is Higher Than the Average Time to Receive a Florida License, Physicians May Receive Multiple Licenses Under the Compact Process

Licensure Process	Average Number of Days to Receive an LOQ	Average Number of Days to Receive a License	Total Time (in Average Number of Days) to Receive a License	Type of License Received
Florida Licensure	N/A	10-15 days ^{1,2}	10-15 days ^{1,2}	Florida License
Compact Licensure	36 days	19 days	55 days	One or more licenses in compact state(s) of physician's choice

¹ The average number of days for licensure was 10 days for osteopathic physicians and 15 days for medical doctors.

² This is the average time to receive a license under circumstances where there are no complications or missing information from the applications.
Source: OPPAGA analysis of Florida Department of Health data and commission data.

⁷ As of June 2019, the commission had received 3,402 applications and member states had issued 6,281 licenses.

⁸ This data is based on the compact's review of 2,845 applications from April 2018 through April of 2019.

What Do Other States Report About Their Experiences With the Compact?

As of September 2019, 29 states, the District of Columbia, and Guam have enacted legislation to join the compact. Of these, 23 states are active members of the compact, while the rest have delayed implementation or are in the process of implementing their membership. OPPAGA contacted the member boards that have enacted legislation to join the compact to learn about their experiences with the compact.⁹ Of the states that have delayed implementation or are in the process of implementation, three states' statutory dates for implementation have not occurred as of September 2019, and three states, the District of Columbia, and the Territory of Guam have left the decision of when to implement the compact to their individual member boards.^{10,11}

Member states reported that they joined the compact to benefit from its expedited licensure process and to increase the supply of physicians in their state. Some member boards that enacted statutes to join the compact reported that they were primarily motivated by the prospect of an expedited licensure process for physicians. States that have implemented the compact and are actively processing licenses reported that the compact application process is easier and faster than their states' traditional licensure processes. Some states also reported an increase in the supply of medical specialists, such as radiologists. Commission staff stated that another benefit realized by member states is an increased ability of physicians to practice at regional medical centers, which can serve patients across state lines.

Member states reported needing time to develop their infrastructure to process applications received through the compact. Member states' preparation to implement the compact involved adjusting their existing processes to accommodate applicants who sought licensure via the compact. For example, states needed to adjust their internal databases to enable them to track which licenses were issued through the compact versus those that were granted through their traditional processes. Personnel also needed training to process these applications, and some states reported that they assigned a dedicated staff member to handle compact licenses, although no state reported needing to hire additional staff for this purpose. In addition, other states reported that they needed to adjust their fiscal processes in order to manage the collection of fees associated with the compact. The Florida Department of Health estimates that they would need three additional staff and an effective date of October 2021 to allow them enough time to make required changes to rules, forms, and technological infrastructure necessary to process licenses through the compact.

Member states reported that the primary legal issue they encountered was not having the statutory framework for FBI background checks. Some states' statutory frameworks did not allow for FBI background checks, and therefore they added statutory language to accommodate this provision of the compact. This is not a concern for Florida, as it currently has the statutory framework for FBI background checks and these checks already constitute a part of Florida's licensure process.

⁹ OPPAGA contacted 28 compact states and the District of Columbia and received information from 15 compact states.

¹⁰ Michigan, Oklahoma, and Vermont have statutorily established dates for implementation. Georgia, Kentucky, the District of Columbia, and the Territory of Guam have left the decision of when to implement the compact to their individual member boards.

¹¹ Michigan's date of implementation falls within the month of September 2019, but the state had not implemented the compact at the time of publication of this report.

How Does Medical Licensure Currently Work in Florida?

The Florida Department of Health regulates physicians to preserve the health, safety, and welfare of the public. The department houses two boards of medicine that govern Florida's physicians. The Florida Board of Medicine licenses, monitors, disciplines, and educates medical doctors, while the Florida Board of Osteopathic Medicine licenses, monitors, disciplines, and educates osteopathic physicians.

Initial medical licensure in Florida requires applicants to demonstrate proof of medical training and a successful background check; license renewal requires physicians to update the Department of Health on their recent medical practice. Physicians pursuing initial licensure in Florida can apply to the department if they are at least 21 years of age and are of good moral character. Applicants must show proof of specific pre-professional postsecondary education, be a graduate of medical school, complete an approved residency for allopathic or osteopathic medicine, and demonstrate successful passage of applicable medical examinations.¹² Prospective physicians must also submit a set of fingerprints to the department to allow them to conduct a criminal background check. The licensing process involves the collection of credentials from the applicant and from other sources. Once all materials are submitted to the department, an application specialist reviews them and requests additional materials if necessary. The licensure application and application fee are valid for one year. According to the department, 5,797 physicians applied for a medical doctor or osteopathic physician license in Fiscal Year 2018-19, with 62% of the applications coming from outside of Florida. (See Exhibit 6.)

Exhibit 6

The Majority of Physicians Who Applied to Practice Medicine in Florida During Fiscal Year 2018-19 Were Out-of-State Physicians

Profession	In-State	Out-of-State	Total	Percent Out-of-State
Medical Doctors	1,807	3,175	4,982	64%
Osteopathic Physicians	416	399	815	49%
Total Physicians	2,223	3,574	5,797	62%

Source: OPPAGA analysis of Florida Department of Health data.

Physicians who wish to renew their Florida license must complete a renewal application and pay associated fees, show evidence that they have practiced medicine or have been on the active teaching faculty of an accredited medical school for specified periods of time, and confirm their continuing education requirements.¹³ Medical doctor applicants must also verify status relating to prescribing controlled substances for the treatment of chronic nonmalignant pain. Physicians must update this publicly available information with the department.¹⁴

The compact would provide another option for out-of-state physicians who wish to provide health care services in Florida. Florida provides two options for physicians from other states who wish to practice medicine or provide health care services to Floridians. Physicians who practice in

¹² The pre-professional postsecondary education requirements are two years for medical doctors and three years for doctors of osteopathic medicine.

¹³ Medical doctors must have remained active for at least two of the immediately preceding four years; osteopathic physicians must have remained active for at least two consecutive biennial licensure cycles.

¹⁴ Physician information required at the time of renewal includes their current primary place of practice address (for medical doctors only), updates to their practitioner profile, a completed Physician Workforce Survey, and a financial responsibility form.

other states may pursue a license in Florida in lieu of taking the state's required exams.¹⁵ These requirements for licensure in lieu of examination are substantially the same as licensure by examination.¹⁶ The licensing process involves the collection and verification of credentials from the applicant and from other sources, and the licensure application and application fee are valid for one year. Out-of-state physicians also currently have the option to register with the Department of Health to use telehealth to deliver health care services to Florida patients.^{17,18} The provider is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.^{19,20} The compact would provide a third option for physicians from other states who wish to practice medicine in Florida. (See Exhibit 7.)

Exhibit 7

Florida Offers Two Options for Out-of-State Physicians to Provide Health Care Services in Florida; the Compact Would Provide a Third Option

Licensure Component	Licensure in Lieu of Examination	Telehealth Registration	Compact License
Physician Eligibility	Any out-of-state physician	Any out-of-state physician	Compact member state physicians
License Type Granted	Full and unrestricted	None	Full and unrestricted
State of Licensure	Florida	Out-of-state	Compact member state(s) of physician's choice
State of Practice	Florida	Florida	Compact member state(s) of physician's choice
Type of Practice	In-person or telehealth	Telehealth	In-person or telehealth
Fee	\$755 for osteopathic physicians \$955 for medical doctors	No fee	\$700 application fee plus compact member state(s) licensure fee(s)

Source: OPPAGA analysis of Florida's licensure in lieu of examination, Florida's telehealth registration, and compact medical licensure processes.

¹⁵ To be considered, a physician must pay the application fee and must have done the following: 1) passed all parts of the national medical examinations and 2) been licensed and actively practicing medicine in another U.S. jurisdiction for two of the last four years, have passed a board-approved clinical competency exam one year prior to application, or have successfully completed a board-approved post-graduate training program within two years prior to application.

¹⁶ Section [458.313, F.S.](#), governs licensure by endorsement for medical doctors. Section [459.0055\(2\), F.S.](#), governs a similar process for osteopathic physicians.

¹⁷ Chapter [2019-137, Laws of Florida](#), established a telehealth registration for out-of-state physicians to practice in Florida.

¹⁸ Section [456.47, F.S.](#), defines telehealth as the use of synchronous or asynchronous telecommunication technology to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of a medical data; patient and professional health-related education; public health services; and health administration. The definition does not include audio-only telephone calls, email messages, or facsimile transmissions.

¹⁹ The department is required to publish specific information about all out-of-state telehealth registrants via a public website, including specialty board certification, five-year disciplinary history (including sanctions and board actions), and medical malpractice insurance provider and policy limits.

²⁰ Chapter [2019-137, Laws of Florida](#), allows the department to initiate rulemaking to establish a telehealth provider registration process.

How Would Compact Membership Affect Medical Licensure and Disciplinary Processes in Florida?

Compact member states retain control over several licensure and discipline-related activities, such as the regulation of the practice of medicine in their state and licensure renewal processes and standards. (See Exhibit 8.) Physicians who wish to obtain licenses in member states can still choose to obtain a license in those states through states' existing licensure paths. Physicians who decide to use the compact and its expedited licensure process also opt in to the compact's rules governing eligibility determinations, discipline, and due process. The compact allows certain determinations to be challenged only in the state of principal license and other determinations to be challenged in each member state making the determination. Choosing the expedited licensure path appears to limit physician due process in some instances. If Florida decided to join the compact, physicians would challenge Florida's determinations through the Administrative Procedures Act (Ch. 120, *Florida Statutes*). For disciplinary actions that may occur in other states, Florida physicians would avail themselves of those states' due process procedures.

Exhibit 8

Compact Member States Retain Control Over Several Licensure-Related Activities

- States of principal license determine eligibility of compact applicants
- Issue licenses to out-of-state physicians with letter of qualification
- Regulate the practice of medicine
- Discipline physicians
- Control renewal standards and processes for physicians licensed through the compact

Source: Commission staff and OPPAGA analysis of compact law and rules.

Physician Information Sharing

Florida would be exempt from disclosing confidential records to the commission. The commission maintains a coordinated information system, which is a database that includes all compact physicians' application information, as well as any available disciplinary and investigative information, if applicable. All state medical boards participating in the compact are required to report to the commission any complaints or public action against a compact-issued physician. Public actions include disciplinary actions, fines, reprimands, probations, conditions or restrictions on a license, suspensions, cease and desist orders, and revocations or denials of licensure. These must be reported no later than 10 business days after a public complaint or public action against an applicant or compact physician has been entered. Each member board will also submit an updated report to the commission when the status of the reported action changes. When the commission receives notice of a final public action by a member board, it will notify the member boards in all other member states where the physician is licensed. On request of another member board, each board must share the requested information from an investigative file as soon as reasonably possible, and that information is confidential.

All information provided to the commission about physician complaints and actions are confidential and may only be used by member boards for investigations and during disciplinary processes. The compact deems closed records from member states exempt from disclosure to the commission. In Florida, the complaint investigation process is confidential until probable cause is established, therefore, the records associated with the investigation would be deemed closed records and exempt from disclosure to the commission.²¹

²¹ Section [456.073\(10\)](#), F.S.

Florida could voluntarily participate in joint investigations of compact physicians. A member board may voluntarily participate with other member boards in joint investigations of physicians through sharing investigative, litigation, or compliance materials. The lead investigative board would inform the commission, direct the investigation, update participating member boards of any developments, and request that member boards participating in the joint investigation conduct investigations in their own states. When a member board issues a subpoena, it is enforceable in other member states, regardless of whether the subpoena concerns a compact physician or applicant.²² The local member board is required to issue a subpoena on behalf of the investigating member board if the individual or entity refuses to comply with the subpoena. All member boards participating in a joint investigation are required to share investigative information, litigation, or compliance materials, upon request of any member board where the compact physician under investigation is licensed. Closed information may be shared, but disclosure is not mandatory.

Any member board may investigate actual or alleged violations of a statute authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine. Prior to initiating an investigation in another state, the investigating member board must contact the other member board and inform them about the investigation. Upon conclusion of the investigation, the investigating member board shall inform the other member boards regarding investigation results. The lead investigative board will report the final outcome of any joint investigation to the commission.

License Renewal

Florida would be able to retain oversight and enforcement of its existing license renewal processes and would be responsible for providing renewal notices to compact physicians. Each license obtained through the compact is valid for the time set by each member state for any physician holding a full and unrestricted license in that state. When the license needs to be renewed, each member state board provides a notice to the physician via email no fewer than 90 days prior to the expiration date of the license that contains the expiration date, a link to the commission webpage, and the renewal fee amount due. The physician is responsible for renewing the license prior to its expiration. A physician seeking to renew an expedited license granted in a member state can complete a renewal process with the commission if the physician

- 1) maintains a full and unrestricted license in a state of principal license;
- 2) has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- 3) has not been subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to a non-payment of fees related to a license; and
- 4) has not had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration.

After the physician completes the renewal process for the commission, including submitting the state board fee and \$25 to the commission for the renewal processing and completing the attestation form in DocuSign, the renewal board state renews the license and updates DocuSign with the new license information. The physician is then notified via email that the license has been renewed.

²² Florida adopted the Uniform Foreign Depositions and Discovery Act, which would govern this process.

Any member states' boards that have requirements for physicians to renew their medical licenses, such as continuing medical education or completion of a physician's workforce survey, would inform the physician who has been relicensed under the compact of these requirements. The boards could discipline the physician according to their standard practice if they did not comply.

Disciplinary Actions and Due Process

Compact disciplinary provisions are not applicable to Florida physicians licensed through the traditional pathways. If a Florida physician who is licensed in the state through the traditional path and has chosen not to designate Florida as their SPL also holds licenses through the compact in other states, the commission would not notify Florida of a license revocation or suspension in those states. Under the terms of the compact, Florida would not be required to revoke or suspend the physician's license. In accordance with existing Florida law, the physician would be required to report the revocation or suspension to the licensing board.

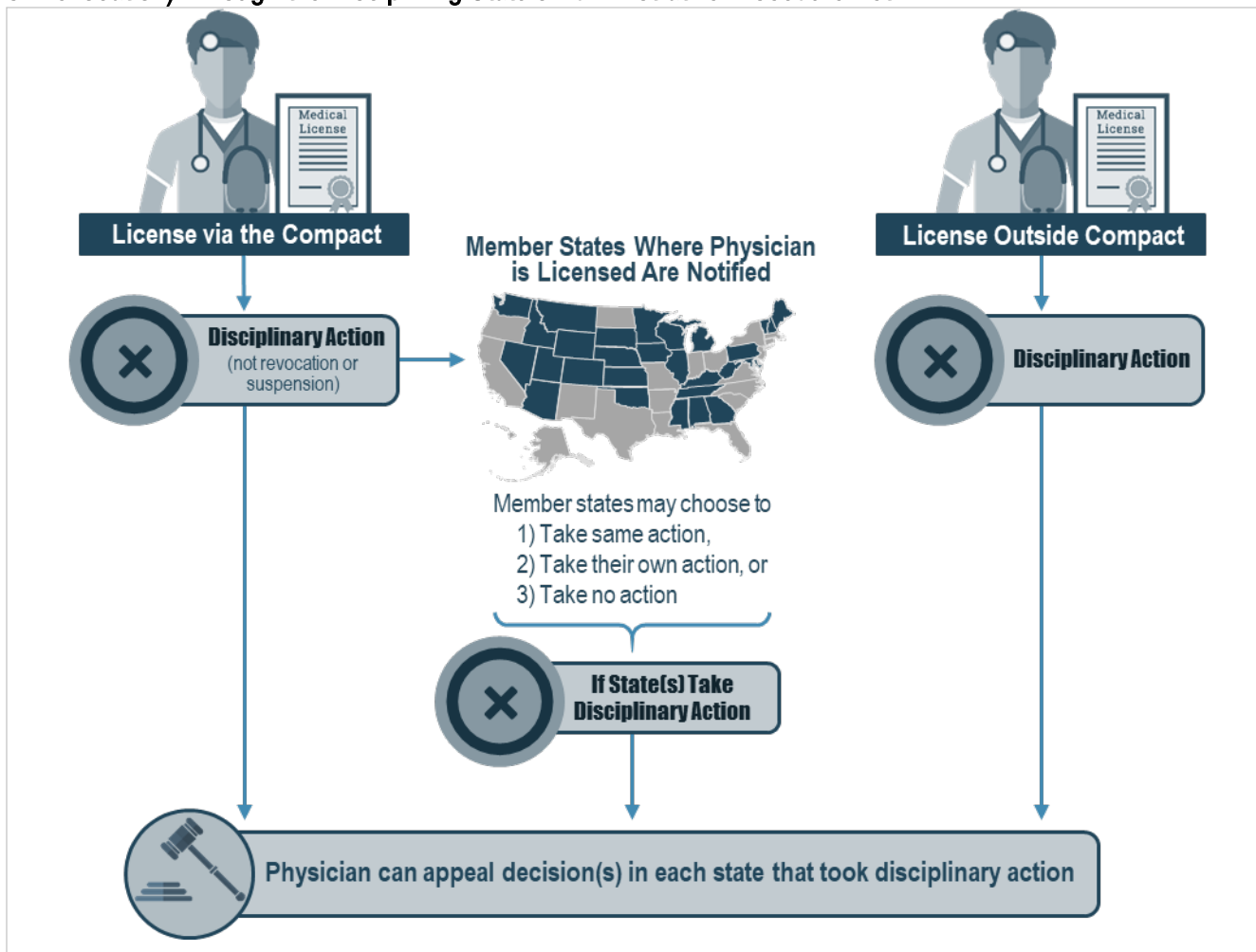
Other than license suspension or revocation, Florida would retain control over disciplinary actions. Florida oversees the practice of medicine in the state and allows physicians substantially affected by a state determination to challenge that decision through Florida's Administrative Procedure Act. This process remains intact through the compact. If any participating board receives a complaint or takes public action against a physician who received a license via the compact, they must notify the commission, which will then notify all member states where the physician obtained a license through the compact. If the member board takes disciplinary action against the physician, other than suspension or revocation of license, other member boards where the physician is licensed may decide to take the same action, take their own action, or take no action.

As each member state maintains authority over physicians' practice of medicine in their state, the member state also retains control over physician discipline. Physicians subject to discipline by a member state may challenge the member state's determination through that state's existing due process procedures. (See Exhibit 9 and Appendix B.)

Under the terms of the compact, being disciplined in another state is considered "unprofessional conduct" and may be subject to discipline by other member boards regardless of whether the underlying violation has a corresponding violation in the member state's medical practice act. For example, if a Florida physician who designates Florida or another state as their SPL receives a letter of concern from the Florida Board of Medicine as discipline for false, deceptive, or misleading advertising under s. 458.331, *Florida Statutes*, Florida would send a copy of this discipline to the commission, which would notify other member states where that physician holds a license. If false, deceptive, or misleading advertising is not a violation of another member state's medical practice act, the member state may still discipline the physician for unprofessional conduct. In this instance, the physician may challenge Florida's determination of false, deceptive, or misleading advertising under Florida's Administrative Procedure Act and may also challenge the other state's determination of unprofessional conduct under that member state's administrative procedure act. Physicians licensed in Florida through the traditional path would maintain their right to challenge such determinations through Florida's Administrative Procedure Act.

Exhibit 9

Physicians Licensed Through the Compact Can Appeal Disciplinary Actions (Other Than License Suspension or Revocation) Through the Disciplining State's Administrative Procedure Act



Source: Commission staff and OPPAGA analysis of compact laws and rules.

When an SPL revokes or suspends a compact physician's license, the physician may only appeal the underlying action through the SPL's due process procedures. If a license granted to a physician by their SPL is revoked, surrendered, relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards would automatically be placed on the same status. Under the terms of the compact, the physician may appeal the ruling in the SPL through that state's established administrative procedure act. The physician may also appeal the member state revocation or suspension under the member state's due process procedure but may not challenge the underlying determination in the member state (i.e., they may appeal the disciplinary action but not the reason for the disciplinary action).

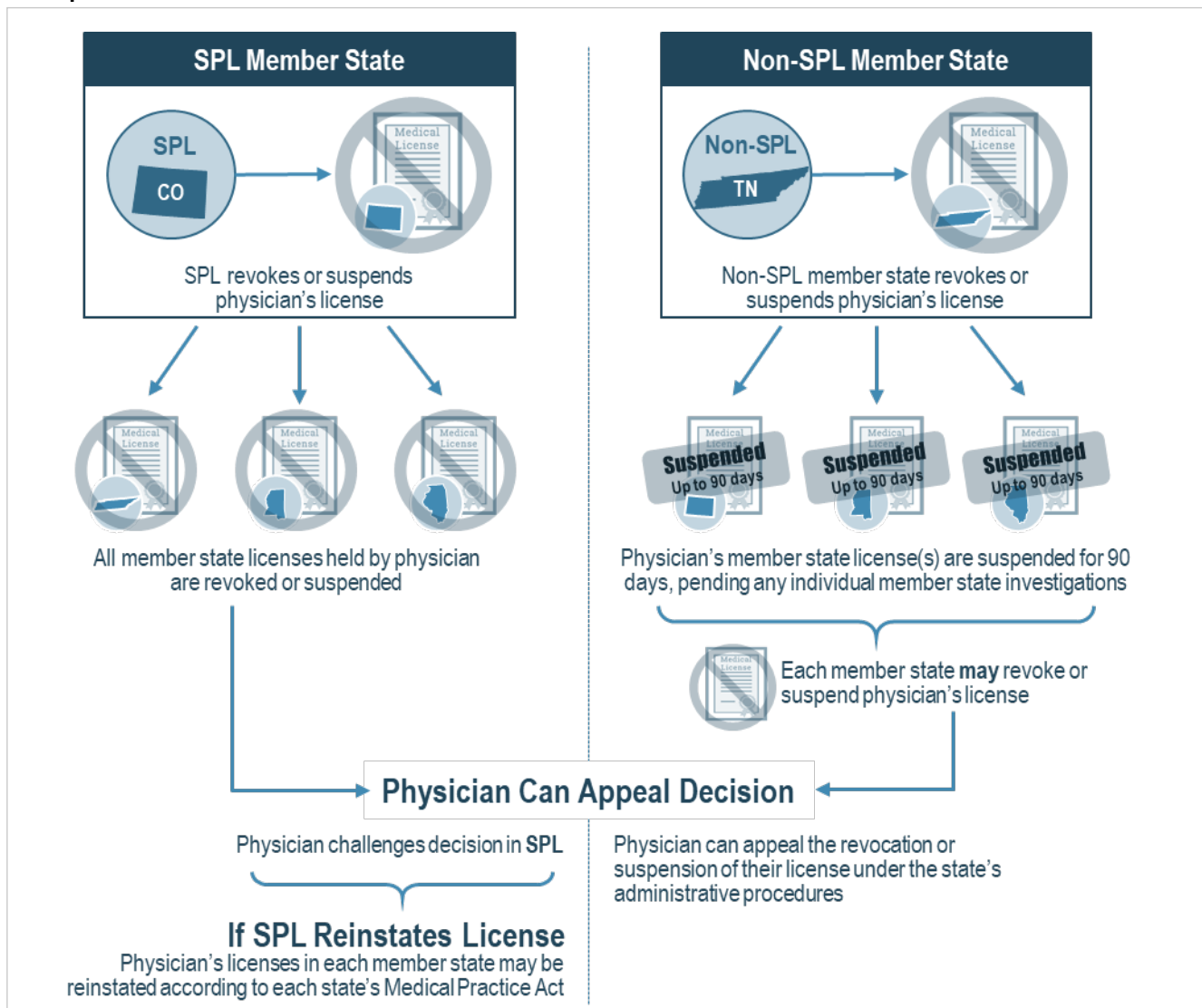
If the SPL member board subsequently reinstates the physician's license, then all of the member states in which the physician holds a compact license may reinstate the physician's license in the manner consistent with each state's medical practice act. Although the physician would be ineligible to renew their license through the compact if the revocation or suspension is upheld (because any disciplinary action disqualifies a physician from applying via the compact), they could still apply to be licensed in the traditional way in any state.

For example, if Florida as a member state received notice from the commission that an SPL revoked or suspended the license of a Florida physician licensed through the compact for a violation of the SPL's medical practice act, Florida would be required to revoke or suspend that physician's license. Under the terms of the compact, which the physician accepted by applying for licensure through the compact, that physician could appeal the SPL's decision as it relates to the violation of the SPL's medical practice act under that state's administrative procedure act. In Florida, the physician would only be able to appeal Florida's revocation of the Florida license or other determination pending investigation, not the violation of the SPL's medical practice act, which is the underlying reason for revocation or suspension. The physician would still be able to apply for a Florida license through the traditional path.

Revocation or suspension of a physician's license in a non-SPL state allows each member board in the states where that physician holds a license through the compact to investigate and choose to reinstate or terminate the license. If a license granted to a physician by a non-SPL member board is revoked, surrendered, relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board would be automatically suspended for 90 days upon entry of the order by the disciplining board. This permits the member boards time to investigate the basis for the action under the medical practice act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the 90-day suspension period in a manner consistent with the medical practice act of that state. (See Exhibit 10 and Appendix B.)

Exhibit 10

Physicians Licensed Through the Compact Can Appeal License Revocation or Suspension in Their State of Principal License and in Member States



Source: Commission staff and OPPAGA analysis of compact laws and rules.

What Compact Provisions Appear to Conflict With the State's General Laws and Constitution and What Actions Could the Legislature Take to Resolve Such Conflicts?

If Florida joined the compact, it would enter into a formal contract that binds the state to the compact's provisions. Compact states are bound to observe the terms of their agreements, which are adopted by statute and take precedence over any conflicting state laws. The whole of the compact language must be adopted by prospective member states' statutes, and any changes to compact provisions must also be adopted by each member state.

If Florida were to seek entrance into the compact, the state would need to address several conflicts that currently exist between Florida law and compact language. Because the compact language states that conflicts between compact language and state statutes must be resolved in favor of the compact, some of these conflicts may be addressed by virtue of adopting the compact language in state statute, while others may need to be addressed more directly. If the Legislature wished to explicitly provide statutory limitations and exemptions in accordance with existing practices, it may also consider adopting additional statutory changes, several of which are similar to statutory changes made when Florida joined the Nurse Licensure Compact.²³ If Florida does not wish to make statutory changes or otherwise accept the existing compact language, the Governor or the Legislature would need to work with the compact and its member states to make changes to the compact language to be adopted by all member states.

Licensure Qualifications

As a compact member, Florida would retain the right to regulate the practice of medicine but would need to waive additional initial licensure requirements; Maryland uses the disciplinary process to address licensure discrepancies that are administrative in nature. While the process of obtaining a license through the compact differs from the traditional method, the license itself will be issued by a state medical board. The compact affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter. A member state must issue a license authorizing a “physician to practice medicine in the issuing state consistent with the medical practice act and all applicable laws and regulations of the issuing member board and member state” based upon verification that a physician meets the eligibility requirements of the compact and has paid their fees. If a member state has additional initial licensure requirements in its medical practice act, it must waive these requirements for the compact physician and issue the physician an unencumbered license to practice in the state. The member state cannot issue a license that deems the physician ineligible pending completion of the additional requirements, nor can it statutorily require additional criteria, as the compact provides that conflicts between state law and the compact be resolved in favor of the compact.

Florida has a general licensure provision that requires license holders to comply with any statutory or legal obligation placed on a licensee. The Department of Health uses the U.S. Department of Health and Human Services’ List of Excluded Individuals/Entities, which includes several criminal offenses and other noncriminal and non-license related provisions, such as nonpayment of student loans, to make this determination.²⁴ This provision does not appear to have a comparable requirement in the compact. Under the terms of the compact, in those instances where a physician who seeks Florida licensure through the compact appears on the List of Excluded Individuals/Entities for nonpayment of student loans, Florida would be required to waive this eligibility criterion and issue a license to the applicant. The Legislature could consider repealing one or more of Florida’s licensure provisions that fall outside of the compact’s licensure requirements.

²³ Florida joined the Nurse Licensure Compact in 2016. This compact is administered by the National Council of State Boards of Nursing and grants a multistate license to nurses based on licensure in their state of primary residency; the multistate license also allows them to practice nursing in other compact member states without having to obtain a second license.

²⁴ See Ch. 456, F.S., and 42USC s. 1320.

Other states have used the disciplinary process to address discrepancies in licensure requirements that are administrative in nature. For example, Maryland requires physicians to enter demographic information into a database as a condition of licensure. To address this discrepancy between Maryland law and the compact, Maryland's statutes create a definition of "compact physician" and require that compact physicians provide verification that the physician satisfies the requirements for licensure and that refusal to provide the requested verification may not be considered a basis for denying licensure under the compact. Instead, physicians licensed through the compact in Maryland who refuse to provide the verification form may be disciplined under Maryland's Medical Practice Act. The disciplinary action would then make the physician ineligible for expedited licensure under the terms of the compact.

Due Process

Through statute, Florida could expand due process rights for physicians who might face license revocation or suspension through the compact. While Florida physicians whose SPL is designated in Florida would have full due process rights in Florida, those who designate an SPL other than Florida would have more limited due process rights. The compact language would limit physicians' ability to challenge the underlying reasons for SPL license revocation and suspension to the SPL only, despite requiring other member states to revoke or suspend the physician's license at the same time. Under current Florida laws and compact provisions, Florida, as a compact member state, would be required to adopt an SPL revocation or suspension determination without providing the physician with due process in Florida for the underlying reasons for suspension or revocation.²⁵ The physician would only be able to challenge whether Florida followed the compact process for revocation or suspension subsequent to SPL-initiated revocation or suspension. Although physicians would voluntarily submit themselves to the terms of the compact and thereby also submit to this limited due process channel, the Legislature could consider statutory changes to Ch. 456, *Florida Statutes*, to provide physicians in these circumstances with the opportunity to challenge the underlying reason for revocation or suspension as well as Florida's revocation or suspension of the license.²⁶

Sovereign Immunity

To address concerns over sovereign immunity, Florida could enact statutory changes comparable to those made in response to similar concerns raised with the Nurse Licensure Compact. The Florida Constitution, under s. 13, Art. X, allows the state to create statutory limitations to sovereign immunity. Under s. 768.28, *Florida Statutes*, Florida allows suits to be brought against the state regarding personal injury suffered by individuals as the result of negligent actions of the state committed within the course and scope of carrying out official government acts. Compact bylaws provide the commission with immunity from suit and liability; thus, by adoption of the compact, Florida would afford the commission immunity and the same limited protections from criminal prosecution and civil suits as the state of Florida affords itself and its employees. Compact bylaws offer indemnification if the act is not negligent. While the constitution explicitly allows waiver of sovereign immunity by law, it is s. 768.28, *Florida Statutes*, that provides the framework for these waivers. As

²⁵ Compact provisions state that determinations of eligibility by the SPL must be challenged within 30 days. Under Ch. 120, *F.S.*, such determinations must be challenged within 21 days. The Legislature may want to consider providing statutory language that requires determinations of eligibility for compact licenses to be challenged within 30 days.

²⁶ In considering such changes to statutory language, the Legislature may also wish to consider allowing for a path to traditional Florida licensure for physicians whose appeals are successful, since the physician's original letter of qualification would be invalid.

Florida may need to clarify tort liability and indemnification on behalf of the compact, the Legislature may consider language similar to that used to accommodate the terms of the Nurse Licensure Compact. When joining the Nurse Licensure Compact, tort limitation language was included in s. 768.28, *Florida Statutes*, clarifying that the compact will pay any claims or judgments arising from commission employees' employment-related actions in the state.

Commission Meetings

Florida could provide statutory exemptions to address the concern that closed meetings allowed under the compact appear to violate the state's constitution and Sunshine Law. Under the Florida Constitution and the Sunshine Law, the public is entitled to notice of and access to government meetings as well as to copy and inspect meeting records. Adoption of the compact language would include a provision allowing the compact to hold closed meetings under certain circumstances, which would conflict with Florida's Constitution and Sunshine Law.²⁷ The Florida Constitution allows for exemptions to these provisions to be created, but also requires that these exemptions be presented to the Legislature as a single subject bill with a statement of public necessity. Because of this requirement, simple adoption of the compact language would not appear to address the constitutional issue. However, Florida has provided statutory exemptions for these types of meetings in other instances. For example, Florida faced a similar challenge when considering adopting the Nurse Licensure Compact, and the Legislature addressed the issue by providing an exemption allowing this closed meeting practice in s. 464.0096, *Florida Statutes*. The Legislature may consider exemption language similar to that provided to the Nurse Licensure Compact to address conflicts with existing public meetings requirements.

Commission Rulemaking Authority

While Florida delegates rulemaking authority to the compact, compact rules provide a mechanism for challenging proposed rules. Some stakeholders voiced concerns that the compact authorizes the commission to develop rules that member states must adopt, which is potentially an unlawful delegation of legislative authority. The Legislature grants rulemaking authority to various agencies through statutory delegations. While these agencies have authority to make rules, the Legislature still oversees rulemaking and reviews proposed and adopted rules. Adoption of the compact would provide a delegation of rulemaking authority to the commission without the Legislature's additional oversight, thus binding Florida to rules that the Legislature has not approved.

Of interest is the fact that the Legislature delegated similar rulemaking powers to the Nurse Licensure Compact when it adopted its language into statute. The rules adopted by the Nurse Licensure Compact are now applicable to Florida without the Legislature's subsequent approval, similar to what the state would encounter with the Interstate Medical Licensure Compact adoption and included rulemaking provision. In the case of the Interstate Medical Licensure Compact, should Florida find that rules adopted by the commission are not acceptable, commission rules provide a mechanism for challenging proposed rules in U.S. District Court. Furthermore, the state always maintains the ability to withdraw from the compact.

²⁷ Under Section 11(h) of the Interstate Medical Licensure Compact, meetings may be closed in full or in portion by a two-thirds vote if an open meeting discussion would include personnel issues, matters exempt from federal disclosure, confidential information, criminal accusations or censure, personal privacy, or legal proceedings.

Public Records

Concerns that documents gathered during the compact application process are considered confidential may be addressed by adding a statutory exemption. In Florida, records associated with government business are public records and must be provided to the public unless a specific exemption prohibits such disclosure, which allows access to much of a physician's file. Under the compact, only the SPL and the commission, not other licensing member states, receive the underlying documents associated with a letter of qualification. Thus, unless Florida is the physician's SPL, the compact and the SPL would be the records custodians for the physician's underlying LOQ documents. Under Section 8 of the compact, all records received by the commission regarding the physician's application are considered confidential.

If Florida adopts the compact language, it would be creating a de facto records exemption for those records in the hands of the compact, whereas the records would typically be subject to Florida's public record laws.²⁸ To address this conflict, the Legislature would need to adopt a statutory exemption protecting these records from public records disclosure.²⁹ In addition, concerns regarding access to these underlying documents could be addressed by requiring that physicians licensed through the compact provide Florida with copies of all documents provided to the SPL and compact as one of the criteria for practicing medicine in Florida via Ch. 456, *Florida Statutes*.

The Legislature could consider several statutory and policy-related changes to address the various challenges associated with Florida joining the Interstate Medical Licensure Compact. Some of these options were used to address similar challenges related to the Nurse Licensure Compact, which Florida joined in 2016. (See Exhibit 11.)

²⁸ As an SPL, Florida would have these records through the initial licensing process, and they would be subject to existing public records law.

²⁹ The Florida Constitution allows for exemptions to be created but also requires that these exemptions be presented to the Legislature as a single subject bill with a statement of public necessity. Because of this requirement, simple adoption of the compact language would not appear to address the constitutional issue.

Exhibit 11

The Legislature Could Consider Several Options Regarding Florida's Prospective Entrance Into the Compact

Consideration	Option	Change Also Made for Nurse Licensure Compact
Licensure Qualifications: Compact eligibility requirements do not include all of Florida's eligibility requirements.	Repeal one or more of Florida's initial licensure provisions that fall outside of the compact's licensure requirements by amending Ch. 456 , <i>F.S.</i>	
Due Process: Florida must revoke or suspend a compact physician's license if their state of principal license revokes or suspends their license; due process regarding the underlying reasons for revocation occurs only in the state of principal license.	Enact statutory language providing physicians who practice in Florida and had their license revoked in their state of principal license an opportunity to challenge the reason for revocation or suspension in Florida.	
Sovereign Immunity: Florida would afford the commission the same indemnification and limitations provided by Florida Constitution and statute.	Enact statutory language clarifying that the compact pays any claims or judgments arising from the commission's employment-related actions in the state by amending s. 768.28 , <i>F.S.</i>	X
Meetings: The compact includes provisions for closed meetings under some circumstances, while Florida requires open meetings.	Enact statutory language providing an exemption allowing closed meetings.	X
Public Records: Application records received by the commission are deemed confidential under compact; Florida requires all records to be public.	Enact statutory language providing an exemption allowing records received by the commission as exempt from disclosure. Provide a statutory exemption for application records by amending Ch. 456 , <i>F.S.</i>	
Infrastructure: Compact member boards report that they needed time to develop infrastructure (e.g., collection of fees, adjustments to databases, training of personnel) to process compact licenses.	Work with the Department of Health to set a compact implementation date to ensure that the department would have adequate time to make required changes to rule, forms, and technological infrastructure in order to process licenses through the compact.	

Source: OPPAGA analysis of compact laws and rules, Florida's Constitution and laws, and information from compact member states.

APPENDIX A

Comparison of Florida's Medical Licensure Requirements With Compact Licensure Requirements

Exhibit A-1

Generally, Florida's Licensure Requirements Are Substantively Similar to or Less Stringent Than Those of the Compact

Interstate Medical Licensure Compact Requirements	Florida Licensure in Lieu of Examination	Florida Medical Doctor (MD) or Osteopathic Physician (DO) Full Licensure	Florida Telehealth Registration ¹
Must hold a full unrestricted medical license in a compact member state	MD and DO: More stringent Has this requirement and an additional one about length of practice in another state or length of time since completing clinical competency examination or length of time since completing a board approved postgraduate training program ²	Does not have this requirement	Substantively the same
Graduated from an accredited medical school or a school listed in the International Medical Education Directory	MD and DO: Substantively the same	MD and DO: Substantively the same	Does not have this requirement
Successful completion of ACGME or AOA accredited graduate medical education (residency training)	MD and DO: Substantively the same	MD and DO: Substantively the same	Does not have this requirement
Passed each component of the USMLE, COMLEX-USA, or equivalent in no more than three attempts	Does not have this requirement	MD and DO: Less stringent For MD, may require additional remedial education after five attempts For DO, no limitation on attempts	Does not have this requirement
Hold a current specialty certification or time-unlimited certification by American Board of Medical Specialties or American Osteopathic Association Bureau of Osteopathic Specialists	MD and DO: Does not have this requirement	MD and DO: Does not have this requirement	Does not have this requirement
Must not have any history of disciplinary actions toward medical license	MD and DO: Substantively the same	MD and DO: Substantively the same	Less stringent Must not have been subject to licensure disciplinary action during the five years prior to submission of application; must not have had license revoked in any state or jurisdiction

Interstate Medical Licensure Compact Requirements	Florida Licensure in Lieu of Examination	Florida Medical Doctor (MD) or Osteopathic Physician (DO) Full Licensure	Florida Telehealth Registration ¹
Must not have any criminal history	MD and DO: Less stringent Cannot have specified classes of felonies after specified time periods ³	MD and DO: Less stringent Cannot have specified classes of felonies after specified time periods ³	Does not have this requirement
Must not have any history of controlled substance actions toward license	MD and DO: Substantively the same	MD and DO: Substantively the same	Does not have this requirement
Must not currently be under investigation	MD and DO: Substantively the same	MD and DO: Substantively the same	Substantively the same
No comparable requirement	MD and DO: Disqualifies applicants who are currently listed on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities ⁴	MD and DO: Disqualifies applicants who are currently listed on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities ⁴	No comparable requirement

¹ Telehealth registration allows a physician in another state to use synchronous or asynchronous telecommunications technology to provide some specific health care services. The provider may not open an office in Florida and may not provide in-person health care services to patients located in Florida.

² The medical doctor needs to have actively practiced medicine for at least two of the immediately preceding four years and the osteopathic physician needs to have practiced for at least two consecutive biennial licensure cycles, or the applicable board may impose further requirements or restrictions.

³ See Ch. [456.0635](#), F.S.

⁴ General licensure provisions in Florida law require that license holders must comply with any statutory or legal obligation placed on a licensee. In practice, the Department of Health uses the List of Excluded Individuals/Entities. This list includes several criminal offenses and other noncriminal and non-license related provisions, such as nonpayment of student loans, which do not appear to have a comparable provision in the compact. See Ch. [456](#), F.S.; 42USC s. 1320.

Source: OPPAGA analysis of ss. [458.313](#), [459.0055\(2\)](#), [458.311](#), [456.47](#), [458.331](#), and [456.0635](#), F.S.; and [Interstate Medical Licensure Compact Law](#).

APPENDIX B

Due Process Scenarios for Florida Physicians Who May Obtain Licenses Via the Compact

Exhibit B-1

Due Process Rights for Florida Physicians Who Also Receive Licenses Via the Compact Would Vary Depending on How the Physician Obtained Their Florida License, Whether They Designate Florida as Their SPL, and the Type of Disciplinary Action

How Florida License Obtained	State of Principal License (SPL)	Type of Disciplinary Action		
		License Revocation or Suspension by Physician's Designated SPL	License Revocation or Suspension by a Physician's Non-SPL	Any Action Other Than License Revocation or Suspension Taken by Any State (SPL or Non-SPL)
Traditional path	Other state	<ul style="list-style-type: none"> All member states revoke or suspend license Full due process through SPL Florida license not affected by compact states' actions¹ 	<ul style="list-style-type: none"> All compact states suspend for 90 days and investigate Due process in compact state(s) that decide to revoke or suspend Florida license not affected by compact states' actions¹ 	<ul style="list-style-type: none"> Due process in each compact state that takes disciplinary action Florida license not affected by compact states' actions¹
Compact	Other state	<ul style="list-style-type: none"> All member states revoke or suspend license Full due process through SPL Due process in Florida for appeal of Florida's suspension or revocation, not for appeal of underlying reason for disciplinary action 	<ul style="list-style-type: none"> All compact states suspend for 90 days and investigate Due process in compact state(s) that decide to revoke or suspend Full due process in Florida if Florida decides to revoke or suspend 	<ul style="list-style-type: none"> Due process in each compact state that takes disciplinary action Full due process in Florida if Florida takes disciplinary action
Traditional path or compact	Florida	<ul style="list-style-type: none"> All member states revoke or suspend license Full due process in Florida 	<ul style="list-style-type: none"> All compact states suspend for 90 days and investigate Due process in compact state(s) that decide to revoke or suspend Full due process in Florida if Florida decides to revoke or suspend 	<ul style="list-style-type: none"> Due process in each compact state that takes disciplinary action Full due process in Florida if Florida takes disciplinary action

¹ Florida license may be affected by the already existing state requirement for physicians to notify boards of any disciplinary actions taken against them.

Source: OPPAGA analysis of Chs. [456](#), [458](#), and [459](#) F.S., compact law and rules, and Florida Department of Health and commission staff.

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THE FLORIDA SENATE
APPEARANCE RECORD

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

10/15/19

Meeting Date

Tab 2

Bill Number (if applicable)

Topic Interstate Medical Licensure Compact

Amendment Barcode (if applicable)

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

Representing OPPAGA

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

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10/15/2019
Meeting Date

Tab 2
Bill Number (if applicable)

Topic IMVC

Amendment Barcode (if applicable)

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

Representing OPPAGA

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 58

INTRODUCER: Health Policy Committee and Senator Book and others

SUBJECT: Prescription Drug Donation Repository Program

DATE: October 15, 2019

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Kibbey	Brown	HP	Fav/CS
2. _____	_____	AHS	_____
3. _____	_____	AP	_____

I. Summary:

CS/SB 58 creates the Prescription Drug Donation Repository Program (Program) within the Department of Health (DOH) to facilitate the donation and distribution of prescription drugs and supplies to eligible patients in the state. The Program:

- Enables Florida residents with valid prescriptions who are indigent, uninsured, or underinsured to receive donated prescription drugs and supplies under the Program;
- Specifies a list of entities that may donate prescription drugs or medical devices to the program and establishes requirements that must be met before donations may be accepted;
- Limits dispensing of prescription drugs under the Program to persons who are licensed, registered, or otherwise permitted by state law;
- Provides procedures for inventorying, storing, dispensing, recalling, and destroying prescription drugs under the Program;
- Provides recordkeeping and reporting requirements for participating facilities;
- Requires the DOH to maintain and publish on its website registries of all participating facilities and available donated drugs and supplies;
- Authorizes the creation of a direct-support organization (DSO) to provide funding for the Program; and
- Requires the DOH to adopt rules necessary to implement the Program.

The bill authorizes the Governor to waive the patient eligibility requirements of the Program during a declared state of emergency.

The DOH will experience an increase in workload to administer the program; however, these costs should be absorbed through funding collected by the DSO in support of the program.

The bill is effective July 1, 2019.

II. Present Situation:

State Prescription Drug Donation and Reuse Programs

State prescription drug donation and reuse programs have been in effect since 1997.¹ Such drug donation and reuse programs permit unused prescription or non-prescription drugs to be donated and re-dispensed to patients within certain federal guidelines. Currently, 38 states have passed laws authorizing such programs; however, not all of these states have operationalized their programs.²

Pharmaceutical donation and reuse programs involve the voluntary collection and re-distribution of donated, unused prescription and non-prescription drugs from participating donors to eligible patients. States vary in the types of drugs and supplies that are accepted, the number and types of sites that are considered eligible locations where donors may deposit donations, participant eligibility requirements, and the dispensing fees for the donated drugs. Generally, the donated drugs are not controlled substances. Some programs, such as Florida's, are limited to only cancer treatment drugs. Twelve other states besides Florida – Colorado, Kentucky, Michigan, Minnesota, Montana, Nebraska, Nevada, Ohio, Pennsylvania, Utah, Washington, and Wisconsin – have prescription drug donation and reuse programs limited to cancer treatment drugs only.

Pharmacies, charitable clinics, and hospitals are locations where such donations are accepted. In Florida's Cancer Drug Donation Program,³ only Class II hospital pharmacies that elect or volunteer to participate are eligible to accept donations of cancer drugs from designated individuals or entities.⁴

Individuals receiving donated drugs may be required to meet certain eligibility requirements beyond a cancer diagnosis to participate in the donation program such as proof of state residency (Minnesota), lack of access to other insurance coverage, or Medicaid ineligibility (Florida). Dispensing fees are set based on a maximum relative threshold above the Medicaid dispensing fee or capped at an absolute dollar amount that typically ranges from \$10 to \$15.

The statutory provisions of many pharmaceutical donation programs have several common requirements:

- No controlled substances are accepted as donations;
- No adulterated or misbranded medications are allowed;
- All donated pharmaceuticals must be checked by a pharmacist prior to being dispensed;
- Pharmaceuticals must not be expired;
- All pharmaceuticals must be unopened and in original, sealed, tamper-evident packaging; and

¹ National Conference of State Legislatures, *State Prescription Drug Return, Reuse and Recycling Laws* (As of Oct. 1, 2018), <http://www.ncsl.org/research/health/state-prescription-drug-return-reuse-and-recycling.aspx> (last visited: Oct. 7, 2019).

² *Supra* note 1.

³ Section 499.029, F.S.

⁴ See s. 465.019, F.S. Class II institutional pharmacies are those institutional pharmacies that employ the services of a registered pharmacist or pharmacists who, in practicing institutional pharmacy, provide dispensing and consulting services on the premises to the patients of that institution, for use on the premises of that institution.

- Liability protection is assured for both donors and recipients.⁵

Most states permit the donation of any non-controlled substance to a designated medical facility, clinic, or pharmacy that has elected to participate in the program. Currently, 15 states allow a non-institutional donor to donate prescription drugs to a donation program under varying degrees of quality control.⁶ Twenty other states have operational repository programs – either cancer drug programs or broader collection programs – including states such as Iowa, which has served over 71,000 patients and re-distributed \$17.7 million in donated prescriptions and supplies since 2007.⁷

The Iowa program is limited to residents with incomes at or below 200 percent of the federal poverty level (FPL), or \$51,500 for a family of four under the 2019 guidelines,⁸ who are uninsured or underinsured, and are eligible to receive the donated medications and supplies.⁹ The Iowa program accepts donations from any organization or individual in the country with the medication provided in its sealed or original sealed container or in tamper-resistant packaging. Any pharmacy or medical facility with authorization to dispense under Iowa administrative rules may re-dispense the donated medication or supplies.¹⁰

Wyoming also has a long-running Medication Donation Program. The state's program filled over 150,000 prescriptions since its inception in 2007 and provided more than \$2.4 million worth of donated prescriptions in 2016.¹¹ A recipient must be a Wyoming resident, have an income under 200 percent of the FPL, and be without prescription insurance or Medicaid coverage. Prescriptions are mailed to the recipient at no cost to the patient; however, neither controlled substances nor refrigerated prescriptions are covered in the program.¹²

Florida Cancer Drug Donation Program

The Florida Cancer Drug Donation Program (CDDP) was created in 2006¹³ and is administratively housed within the Florida Department of Business and Professional Regulation (DBPR). The CDDP allows eligible donors to donate cancer drugs and related supplies to participating facilities that may dispense the donations to eligible cancer patients. The hospital pharmacies accept donations of cancer drugs and supplies from drug manufacturers and wholesalers; health care facilities, including nursing home facilities, hospices, or hospitals with a

⁵ *Supra* note 1.

⁶ *Supra* note 1.

⁷ *Supra* note 1.

⁸ U.S. Department of Health and Human Services, *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs (Effective January 11, 2019)*, <https://aspe.hhs.gov/poverty-guidelines> (last visited Oct. 7, 2019).

⁹ Iowa Department of Public Health, *SafeNetRx Program*, <https://idph.iowa.gov/ohds/rural-health-primary-care/repository>, (last visited Oct. 7, 2019).

¹⁰ *Id.*

¹¹ Wyoming Department of Health, *Wyoming Medication Donation Program*, <https://health.wyo.gov/healthcarefin/medicationdonation/> (last visited: Oct. 7, 2019).

¹² Wyoming Department of Health, *Wyoming Medication Donation Program*, <https://health.wyo.gov/healthcarefin/medicationdonation/application-and-eligibility/> (last visited: Oct. 7, 2019).

¹³ Chapter 2006-310, Laws of Fla. (creating s. 499.029, effective July 1, 2006). It was originally created within the Department of Health, but was part of a programmatic transfer by the 2010 Legislature to DBPR effective October 1, 2011.

closed drug delivery system; or pharmacies, medical device manufacturers, or suppliers; and patients or their representatives.¹⁴ However, all donations to the CDDP must be maintained in a closed drug delivery system.¹⁵

Eligible participating facilities are limited to only those Florida hospital pharmacies with a Class II institutional pharmacy permit.¹⁶ These pharmacies participate on a voluntary basis and must agree to accept, inspect, and dispense the donated drugs to the eligible patients in accordance with the statute. The DBPR is required to establish and maintain a participant facility registry for the CDDP. The law provides the content for the registry and a requirement for a website posting. Currently, the following 15 hospital pharmacies participate in the CDDP.

Cancer Drug Donation Program Participants¹⁷:	
Health Care Facility	Location
Moffitt Cancer Center	Tampa
Shands Hospital at the University of Florida	Gainesville
Sacred Heart Health	Pensacola
Halifax Medical Center	Daytona Beach
Jackson Memorial Hospital	Miami
Adventist Health System/Sunbelt Health Care	Celebration
Indian River Medical Center	Vero Beach
Tallahassee Memorial	Tallahassee
Baptist Medical Center	Jacksonville
Lower Keys Medical Center	Key West
Sun City Hospital, Inc.	Sun City Center
Mt. Sinai Medical Center	Miami Beach
Healthsouth Rehabilitation Hospital of Spring Hill	Brooksville
Baptist Hospital of Miami	Kendall
Palm Bay Hospital	Palm Beach

Florida's recipient eligibility requirements limit participation to Florida residents who:

- Have been diagnosed with cancer; and
- Are ineligible for the Medicaid program, or any other prescription drug program funded in whole or in part by the federal government, or do not have third party insurance unless the benefits have been exhausted or a certain cancer drug is not covered.¹⁸

Donated drugs may only be prescribed by a licensed practitioner and dispensed by a licensed pharmacist to an eligible patient.¹⁹ Dispensed drugs and supplies under the CDDP are not eligible for reimbursement by third parties, either public or private. However, the facility may charge the

¹⁴ Section 499.029(3)(c), F.S.

¹⁵ Section 499.029(3)(b), F.S. A "closed drug delivery system" means a system in which the actual control of the unit-dose medication package is maintained by the facility rather than by the individual patient.

¹⁶ Section 499.029(3)(e), F.S.

¹⁷ Florida Department of Business and Professional Regulation, *Cancer Drug Donation Program Participation Report*, <http://www.myfloridalicense.com/DBPR/drugs-devices-and-cosmetics/cancer-drug-donation-program/> (last visited Oct. 7, 2019).

¹⁸ Rule 61N-1.026(1), F.A.C.

¹⁹ Section 499.029(5), F.S.

recipient of the donated drug a handling fee of no more than 300 percent of the Medicaid dispensing fee or no more than \$15, whichever is less, for each cancer drug that is dispensed.²⁰

The Division of Drugs, Devices, and Cosmetics within DBPR does not maintain a list of available donated medications on its website. The DBPR also does not require the participating facilities to report the medications that are available for re-dispensing in the CDDP or the number of donated drugs that have been administered.²¹ A facility is required to maintain its own data for three years.²²

The CDDP site will only accept drugs if:

- The donation is accompanied by a Program Donation and Destruction Record Form;
- The donation occurs at least six months before the drug's expiration date;
- The donated drug is in the original, unopened tamper-evident unit dose packaging;
- The drug must not be adulterated, misbranded, or mislabeled;
- The donated drug was maintained by a health care facility; and
- The drug is not a substance listed on Schedule II, III, IV, or V of s. 893.03, F.S.²³

A donor or a participant in the CDDP who acts with reasonable care in donating, accepting, distributing, or dispensing prescription drugs or supplies is immune from civil or criminal liability or professional disciplinary action for any kind of injury, death, or loss relating to such activities.²⁴

Regulation of Pharmacy

The DBPR is the state agency charged with the regulation and licensure of businesses and certain professions.²⁵ Under ch. 499, F.S., the Division of Drugs, Devices, and Cosmetics safeguards the health, safety, and welfare of the state's citizens from injury due to the use of adulterated, contaminated, and misbranded drugs, drug ingredients and cosmetics. The Division oversees: the CDDP; issuance and regulation of licensure and permits for drug manufacturers, wholesalers, and distributors; controlled substance reporting requirements for certain wholesale distributors; issuance and regulation of other permits and licenses; and the Drug Wholesale Distributor Advisory Council.²⁶

The Florida Drug and Cosmetic Act (Act) is codified as ss. 499.001 - 499.094, F.S. The Act provides uniform legislation to be administered so far as practicable in conformity with the provisions of, and regulations issued under the authority of, the federal Food, Drug, and Cosmetic Act and that portion of the Federal Trade Commission Act which expressly prohibits

²⁰ Section 409.029(7)(b), F.S. and Rule 61N-1.026(5), F.A.C.

²¹ Email correspondence from the Department of Business and Professional Regulation (Jan. 31, 2019) (on file with the Senate Committee on Health Policy).

²² *Id.*

²³ See Rule 61N-1.026(6), F.A.C. and Florida Department of Business and Professional Regulation, *Florida Cancer Drug Donation Program Brochure*, <http://www.myfloridalicense.com/dbpr/ddc/documents/CDDP.Brochure.pdf> (last viewed: Oct. 8, 2019).

²⁴ Section 409.029(11), F.S.

²⁵ Section 20.165, F.S.

²⁶ Department of Business and Professional Regulation, *Division of Drugs, Devices, and Cosmetics*, <http://www.myfloridalicense.com/DBPR/drugs-devices-and-cosmetics/> (last visited Oct. 8, 2019).

the false advertisement of drugs, devices, and cosmetics. The Act provides definitions for what is considered a device, a drug, and, specifically, a prescription drug.²⁷

Chapter 465, F.S., assigns regulation of the practice of pharmacy to the Board of Pharmacy in the DOH. Section 465.019(2)(b), F.S., provides requirements for institutional pharmacies. “Class II institutional pharmacies” are those institutional pharmacies that employ the services of a registered pharmacist or pharmacists who, in practicing institutional pharmacy, provide dispensing and consulting services on the premises to patients of that institution for use on the premises of that institution.

Section 465.015(2)(c), F.S., makes it unlawful for a pharmacist to sell or dispense medicinal drugs without first being furnished a prescription. Section 465.016(1)(l), F.S., prohibits a pharmacist from placing into stock any part of any prescription compounded or dispensed which is returned by the patient. Additionally, the Board of Pharmacy adopted an administrative rule that prohibits a pharmacist from placing into the stock of any pharmacy any part of any prescription compounded or dispensed, which is returned by a patient, except as specified in the Board of Pharmacy rules.²⁸

There is an exception for a closed drug delivery system in which unit dose or customized patient medication packages are dispensed to individuals who are admitted as inpatients²⁹ to a hospital. The unused medication may be returned to the pharmacy for re-dispensing only if each unit dose or customized patient medication package is individually sealed and if each unit dose or the unit dose system – or the customized patient medication package container or the customized patient medication package unit of which it is clearly a part – is labeled with the name of the drug, dosage strength, manufacturer’s control number, and expiration date, if any. In the case of controlled substances, such drugs may only be returned as permitted under federal law.³⁰

A “closed drug delivery system” means a system in which control of the unit-dose medication is maintained by the facility rather than by the individual patient. A “unit dose system” means a system in which all the individually sealed unit doses are physically connected as a unit.³¹

For nursing facility residents, s. 400.141(1)(d), F.S., requires a pharmacist licensed in Florida that is under contract with a nursing home to repackage a resident’s bulk prescription medication which has been packaged by another pharmacist into a unit-dose system compatible with the system used by the nursing facility, if requested by the facility. In order to be eligible for the repackaging service, the resident or the resident’s spouse’s prescription medication benefits must

²⁷ A “prescription drug” under s. 499.003(40) is defined as a “prescription, medicinal, or legend drug, including, but not limited to, finished dosage forms or active ingredients subject to, defined by, or described by, s. 503(b) of the federal act or s. 465.003(8), s. 499.007(13), subsection (31), or subsection (47), except that an active pharmaceutical ingredient is a prescription drug only if substantially all finished dosage forms in which it may be lawfully dispensed or administered in this state are also prescription drugs.

²⁸ Rule 64B16-28.118(2), F.A.C.

²⁹ Generally, an inpatient is an individual who is admitted to the hospital by a licensed physician or dentist with the expectation that the recipient will stay in excess of 24 hours and occupy an inpatient bed. *See* Agency for Health Care Administration, *Florida Medicaid – Inpatient Hospital Services Coverage Policy* (July 2016), http://ahca.myflorida.com/medicaid/review/specific_policy.shtml (last visited: Oct. 8, 2019).

³⁰ Rule 64B16-28-118(2), F.A.C.

³¹ Rule 64B16-28-118(1), F.A.C.

be covered through a former employer as part of his or her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. part 831, or a long-term care policy as defined under specified state law. A pharmacist who correctly repackages and relabels the medication, and the nursing home that correctly administers the repackaged medication, cannot be held liable in any civil or administrative action arising from the repackaging. The pharmacist may charge a reasonable fee for costs of the repackaging.

A nursing home typically has a Class I institutional permit. This permit authorizes the nursing home to have patient-specific medications that have already been dispensed to the resident. Prescription drugs may not be dispensed in a Class I pharmacy.³²

Federal Law and Regulations

Controlled Substances Act

The federal Controlled Substances Act (CSA) was enacted by Congress in 1970 and codified as 21 U.S.C. §801, et seq. The CSA regulates the manufacture and distribution of controlled substances in the United States. The federal Drug Enforcement Agency (DEA) is responsible for the enforcement of the CSA.

The CSA categorizes drugs into five “schedules” based on their potential for abuse and safety or dependence liability.³³ The CSA provides for specific dispensing requirements for controlled substances, including written prescriptions, retention requirements, and refill restrictions, depending on the drug’s schedule.³⁴ Prescriptions must also meet specific labeling and packaging requirements. For Schedule II, III, and IV drugs, the label must clearly contain a warning that it is a crime to transfer the drug to any person other than the patient.³⁵

The CSA permits the delivery of controlled substances by an “ultimate user,”³⁶ who has lawfully obtained the drug, to a designated covered entity for disposal and destruction such as through a prescription drug take-back program.³⁷ An authorized covered entity is defined in federal law as:

- A specified law enforcement agency;

³² Section 465.019(2)(a), F.S.

³³ U.S. Department of Justice, Diversion Control Division, *Controlled Substance Security Manual*, https://www.deadiversion.usdoj.gov/pubs/manuals/sec/app_law.htm (last visited Oct. 8, 2019). Drugs classified as Schedule I are those that are considered to have no medical use in the United States and have a high abuse potential and include drugs such as heroin, LSD, and marijuana. Schedule II substances have a high abuse potential with severe psychological or physical dependency, but have accepted medical use. Examples of Schedule II drugs include opium, morphine, codeine, and oxycodone. Schedule III drugs have an abuse potential and dependency liability less than Schedule II with an accepted medical use. Schedule III drugs may also contain limited quantities of certain narcotic and non-narcotic drugs. Schedule IV drugs have an abuse potential and dependency liability less than those drugs in Schedule III and have an accepted medical use and include drugs such as Valium, Xanax, and Darvon. The drugs in the fifth and final schedule, Schedule V, have an abuse potential less than those listed in Schedule IV, have an accepted medical use, and are often available without a prescription, including some for antitussive and antidiarrheal purposes.

³⁴ 21 U.S.C. §829 and 21 CFR §§1306.21 and 1306.22.

³⁵ 21 U.S.C. §825.

³⁶ An “ultimate user” is defined under 21 U.S.C. 802(27), as the person who has lawfully obtained, and who possesses, a controlled substance for his own use or the use of a member of his household or for an animal owned by him or by a member of his household.

³⁷ 21 U.S.C. 822a.

- A manufacturer, distributor, or reverse distributor of prescription medications;
- A retail pharmacy;
- A registered narcotic treatment program;
- A hospital or clinic with an onsite pharmacy;
- An eligible long-term care facility; or
- Any other entity authorized by the DEA to dispose of prescription medications.³⁸

The last National Prescription Take Back Day sponsored by the DEA resulted in more than 937,443 pounds of expired, unused, and unwanted prescription drugs returned at 6,258 sites on April 27, 2019, of which 35,775 pounds were collected at 204 Florida sites.³⁹ The goal of the take-back program is to prevent the diversion of unwanted drugs to misuse and abuse and to avoid the potential safety hazard of drugs flushed into wastewater, sewage, or septic tank systems.⁴⁰

Citizen-Support Organizations and Direct-Support Organizations

Citizen-support organizations (CSOs) and direct-support organization (DSOs) are statutorily created non-profit organizations⁴¹ authorized to carry out specific tasks in support of public entities or public causes.⁴² The function and purpose of a CSO or DSO are prescribed by an enacting statute and a written contract with the governmental agency the CSO or DSO supports.⁴³

CSO and DSO Transparency and Reporting Requirements

In 2014, the Legislature created s. 20.058, F.S., establishing a comprehensive set of transparency and reporting requirements for CSOs and DSOs.⁴⁴ The law requires each CSO and DSO to annually submit the following information to the appropriate agency by August 1:⁴⁵

- The name, mailing address, telephone number, and website address of the organization;
- The statutory authority or executive order that created the organization;
- A brief description of the mission of, and results obtained by, the organization;
- A brief description of the organization's plans for the next three fiscal years;
- A copy of the organization's ethics code; and
- A copy of the organization's most recent Internal Revenue Service (IRS) Form 990.⁴⁶

³⁸ *Id.*

³⁹ Drug Enforcement Administration, *17th National Take Back Day Collection Results* (April 27, 2019) https://www.deadiversion.usdoj.gov/drug_disposal/takeback/ (last visited Oct. 8, 2019).

⁴⁰ *Id.*

⁴¹ Chapter 617, F.S.

⁴² *E.g.*, ss. 1009.983 and 413.0111, F.S.

⁴³ *See* ss. 14.29(9)(a), 16.616(1), and 258.015(1), F.S. *See also* Rules of the Florida Auditor General, Audits of Certain Nonprofit Organizations (effective June 30, 2019), available at https://flauditor.gov/pages/pdf_files/10_700.pdf (last visited: Oct. 8, 2019).

⁴⁴ Section 3, ch. 2014-96, L.O.F.

⁴⁵ Section 20.058(1), F.S.

⁴⁶ The IRS Form 990 is an annual information return required to be filed with the IRS by most organizations exempt from federal income tax under 26 U.S.C. 501. 26 C.F.R. 1.6033-2.

Each governmental agency receiving information from a CSO or DSO pursuant to law must make such information available to the public through the agency's website.⁴⁷ If the organization maintains a website, the agency's website must provide a link to the organization's website.⁴⁸ Any contract between an agency and a CSO or DSO must be contingent upon the CSO or DSO submitting and posting the required information to the agency as specified in law.⁴⁹ If a CSO or DSO fails to submit the required information to the agency for two consecutive years, the agency head must terminate any contract between the agency and the CSO or DSO.⁵⁰

By August 15 of each year, the agency must report to the Governor, President of the Senate, Speaker of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability (OPPAGA) the information submitted by each CSO or DSO along with the agency's recommendation and supporting rationale to continue, terminate, or modify the agency's association with the CSO or DSO.⁵¹

Any law creating, or authorizing the creation of, a CSO or DSO must provide that the authorization for the organization repeals on October 1 of the 5th year after enactment, unless reviewed and reenacted by the Legislature. CSOs and DSOs in existence prior to July 1, 2014, must have been reviewed by the Legislature by July 1, 2019.⁵²

CSO and DSO Audit Requirements

Section 215.981, F.S., requires each CSO and DSO with annual expenditures in excess of \$100,000 to provide for an annual financial audit of its accounts and records.⁵³ An independent certified public accountant in accordance with rules adopted by the Auditor General must conduct the audit. The audit report must be submitted within nine months after the end of the fiscal year to the Auditor General and to the governmental agency the CSO or DSO supports.⁵⁴ Additionally, the Auditor General may, pursuant to his or her own authority, or at the direction of the Legislative Auditing Committee, conduct audits or other engagements of a CSO's or DSO's accounts and records.⁵⁵

CSO and DSO Ethics Code Requirement

Section 112.3251, F.S., requires a CSO or DSO to adopt a code of ethics. The code of ethics must contain the specified standards of conduct and disclosures provided in ss. 112.313 and

⁴⁷ Section 20.058(2), F.S.

⁴⁸ *Id.*

⁴⁹ Section 20.058(4), F.S.

⁵⁰ *Id.*

⁵¹ *Id.* at (3).

⁵² *Id.* at (5).

⁵³ The independent audit requirement does not apply to a CSO or DSO for a university, district board of trustees of a community college, or district school board. Additionally, the expenditure threshold for an independent audit is \$300,000 for a CSO or DSO for the Department of Environmental Protection and the Department of Agriculture and Consumer Services.

⁵⁴ Section 215.981(1), F.S.

⁵⁵ Section 11.45(3), F.S.

112.3143(2), F.S.⁵⁶ A CSO or DSO may adopt additional or more stringent standards of conduct and disclosure requirements and must post its code of ethics on its website.⁵⁷

Governor's Executive Powers

During a declared state of emergency, the Governor has extensive authority to act as he or she deems necessary. Section 252.36(1), F.S., provides, in part, that “in the event of an emergency beyond local control, the Governor...may assume” or delegate “direct operational control over all or any part of the emergency management functions within this state...”

In addition, the Governor may “issue executive orders, proclamations, and rules” which “shall have the force and effect of law.” Section 252.36(5), F.S., specifically authorizes the Governor to use all resources of the state government and of each political subdivision of the state as reasonably necessary to cope with the emergency.

The Governor is also directed to “take such action and give such direction to state and local law enforcement officers,” and state health officials as may be “reasonable and necessary” to secure compliance with the State Emergency Management Act and the Florida Hazardous Materials Emergency Response and Community Right-To-Know Act in ch. 252, F.S.

A declared State of Emergency is limited to 60 days unless renewed by the Governor or terminated by the Legislature.

III. Effect of Proposed Changes:

Section 1 creates s. 465.1902, F.S., to establish the Prescription Drug Donation Repository Program (Program) within the Department of Health (DOH). The purpose of the Program is to authorize and facilitate the donation and distribution of prescription drugs and supplies to eligible patients through a system of local and centralized repositories. The DOH may contract with a third party to implement and administer the Program.

The bill authorizes the following individuals or entities to donate prescription drugs and supplies:

- Nursing home facilities with closed drug delivery systems;
- Hospices that have maintained control of a patient's prescription drug;
- Hospitals with closed drug delivery systems;
- Pharmacies;
- Drug manufacturers or wholesale distributors;
- Medical device manufacturers or suppliers; and
- Prescribing individuals who receive prescription drugs or supplies directly from a drug manufacturer, wholesale distributor, or pharmacy.

Patients or a patient's legal representative or next of kin may donate to a local repository that qualifies as a free clinic or nonprofit health clinic if the following specific requirements are met:

⁵⁶ Some of the standards of conduct and disclosures in ss. 112.313 and 112.3143(2), F.S., include misuse of public position, solicitation or acceptance of gifts, unauthorized compensation, and voting conflicts.

⁵⁷ Section 112.3251, F.S.

- An affidavit is signed by the donor on a form approved by the DOH which identifies the prescribing health care practitioner and attests to the authenticity of the prescription drug or medical supply being donated;
- The prescription drug or medical supply being donated is in its original tamper-evident packaging and does not have any signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;
- Any drug being donated has an expiration date that is more than three months after the date of donation; and
- A licensed pharmacist inspects the prescription drug or medical supply and verifies that it meets all of these requirements.

The bill provides that prescription drugs and supplies donated by a patient, a patient's legal representative, or a patient's next of kin are exempt from one, non-applicable safety provision that applies to other donations; however, these donations are subject to all applicable safety and storage requirements of the Program.

The bill authorizes prescription drugs to be donated at the discretion of the centralized repository or a local repository if the drug:

- Is approved for medical use in the United States;
- Does not include a substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03, F.S.;
- Is in its original sealed and tamper-evident packaging and does not have any physical signs of tampering or adulteration;
- Requires storage at normal room temperature per the manufacturer or the United States Pharmacopeia;⁵⁸
- Has been stored according to manufacturer or United States Pharmacopeia storage requirements;
- Will not expire within three months after the donation is made and the drug's packaging contains a lot number and expiration date of the drug;
- Is not eligible for return to the Medicaid program for restocking; and
- Is not subject to a Federal Food and Drug Administration Risk Evaluation and Mitigation Strategy with Elements to Assure Safe Use.⁵⁹

The bill requires that prescription drugs or supplies must be donated at a repository and prohibits the use of a drop box and donation to a specific patient. Repositories must destroy any donated drug not eligible for dispensing and make a record of the destruction on a form developed by the DOH.

⁵⁸ The United States Pharmacopeia is a compendium of drug information published annually by the United States Pharmacopeial Convention.

⁵⁹ The Federal Food and Drug Administration requires drugs with serious safety concerns to have a Risk Evaluation and Mitigation Strategy in place to avoid adverse incidents. See U.S. Food & Drug Administration, *Risk Evaluation and Mitigation Strategies*, <https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rem> (last visited: Oct. 9, 2019).

The bill requires a licensed pharmacist employed by, or under contract with, a repository to inspect all donated prescription drugs and supplies to determine whether they are eligible for donation under the Program, have been adulterated or misbranded, and are safe and suitable for dispensing. The pharmacist must sign an inspection record affirming the eligibility of the prescription drug or supply and attach the form to the inventory record. The pharmacist is not required to re-inspect the prescription drug if the inspected drugs are redistributed to another repository under the Program.

The bill requires repositories to store all donated prescription drugs and supplies in a secure storage area, separate from non-donated inventory, and under the environmental conditions required by the manufacturer or the U.S. Pharmacopeia. Repositories must quarantine donated drugs and supplies from dispensing inventory until they have been inspected and approved for dispensing by the pharmacist.

The bill requires local repositories to maintain an inventory of all donated prescription drugs and supplies they receive and to notify the centralized repository within five days of receipt. The centralized repository must maintain an inventory of all prescription drugs and supplies donated to the Program, including donations made at local repositories. The centralized repository may redistribute drugs and supplies to local repositories to facilitate dispensing as needed throughout the state.

The bill makes participation in the Program voluntary and requires an eligible entity to notify the DOH of its intent to participate before accepting or dispensing any prescription drugs or supplies under the Program. The DOH shall establish in rule a form for such notification, to include, at a minimum:

- The name, street address, website, and telephone number of the local repository, and any state-issued license or registration number issued to the local repository, including the name of the issuing agency;
- The name and telephone number of the pharmacist employed by, or under contract with, the local repository responsible for the inspection of donated prescription drugs and supplies; and
- A statement signed and dated by the responsible pharmacist affirming that the local repository meets the eligibility requirements.

An eligible patient wishing to receive drugs or supplies under the Program may contact a local repository and submit an intake collection form. The form, to be created by the DOH in rule, must include, at a minimum:

- The name, street address, and telephone number of the eligible patient;
- The specific basis for eligibility, which must be indigent, uninsured, or underinsured, as defined in the Program;⁶⁰ and
- A statement signed and dated by the eligible patient affirming that he or she meets the eligibility requirements of the Program.

⁶⁰ The bill defines “indigent” as persons with an income below 200 percent of the federal poverty level, “uninsured” as persons who have no third-party insurance and are not eligible under Medicaid or any other federal program, and “underinsured” as persons who have third-party insurance or are eligible under Medicaid or other federal program, but have exhausted these benefits or do not have prescription drug coverage for the drug prescribed.

The bill requires local repositories to collect an executed intake form from each eligible patient receiving drugs or supplies under the Program. Upon receiving a duly executed intake form, the local repository must issue the eligible patient an identification card that is valid for up to one year. Local repositories must send a summary of the intake collection form data to the centralized repository within five days of receipt.

The bill permits licensed pharmacists and those health care practitioners already authorized by law to dispense prescription drugs and supplies in Florida to do so under the Program. Prior to dispensing a prescription drug or supply to an eligible patient, the dispenser must:

- Verify that the patient is eligible to receive donations under the Program, either through a Program identification card or a duly executed intake collection form; and
- Inspect the donated prescription drug or supply to confirm it is still eligible for dispensing under the Program.

The bill prohibits repositories from reselling drugs, submitting claims, or otherwise seeking reimbursement from any public or private third-party payer for donated drugs or supplies dispensed under the Program. However, the dispensing facility may charge a nominal handling fee to be determined by the DOH in rule.

In the event of a prescription drug recall, the bill requires a local or centralized repository to:

- Have an established protocol to notify recipients of the drug;
- Destroy all of the recalled prescription drugs in the repository; and
- Complete a destruction information form for all donated prescription drugs that were destroyed.

The bill requires local repositories to maintain records of all prescription drugs and supplies accepted, donated, dispensed, distributed, or destroyed under the Program. Local repositories must submit these records quarterly to the centralized repository for data collection and the centralized repository must submit these records and the collected data in annual reports to the DOH.

The bill requires the DOH to maintain a registry on its website of all available drugs and supplies, including the name, strength, available quantity, and expiration date of each drug and supply, as well as the contact information for the repositories where it is available. The DOH is required to maintain a registry on its website of all participating local repositories, to include each repository's name, address, website, and telephone number.

The bill grants immunity from civil or criminal liability, and professional disciplinary actions, to a donor or participant relating to activities under the Program. Additionally, a pharmaceutical manufacturer who exercises reasonable care is not liable for any claim or injury arising from the transfer of prescription drugs under the Program.

The bill requires that, before a donated drug may be dispensed, the dispenser must provide written notification to the patient, or his or her legal representative:

- That the drug was donated to the Program;

- That the dispenser is not liable for any injury, death, or loss related to the dispensing of the drug; and
- Of any nominal handling fee.

The bill authorizes the DOH to establish a direct-support organization (DSO) to provide assistance, funding, and promotional support for the activities authorized for the Program. The DSO is repealed on October 1, 2024, unless reviewed and saved from repeal by the Legislature.

The bill provides rulemaking authority to the DOH to administer the Program and establish the DSO.

Section 2 amends s. 252.36(5), F.S., to allow the Governor to waive the patient eligibility requirements of the Program during a declared state of emergency.

Section 3 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

CS/SB 58 includes the issuance of an identification card to eligible patients who participate in the Program. These individuals are required to submit intake forms to a local repository to determine their eligibility for the Program. Eligibility is based on income and sensitive medical information. The local repository must send a summary of each intake form to the centralized pharmacy. It is not clear if that information would then be stored by the Department of Health, the repositories, or any contracted vendor if a contract is established.

The bill does not address how patient identification information collected during the medication donation process will be handled, or if any of the patient medical information not otherwise protected by other statutes, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA),⁶¹ could be subject to a public records release request since the bill does not have a companion public records exemption bill. If records are subject to a public records release, it may impact participation in the Program.

⁶¹ The Health Insurance Accountability and Portability Act of 1996 or HIPAA, Public Law 104-191, was enacted to address concerns about both the effectiveness and the security of health care data. HIPAA required the federal Department of Health and Human Services to adopt rules relating to national standards for electronic health transactions, health care privacy and security, and health care clearinghouses. The privacy rule component of HIPAA sets standards for the use and disclosure of individuals' health care information, specifically what was protected, who was protected, how it was protected, and how it could be released and used. *See* Health Information Privacy, *HIPAA for Professionals*, <https://www.hhs.gov/hipaa/for-professionals/index.html> (last visited: Oct. 7, 2019).

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:

Facilities participating in the program as repositories may incur costs associated with collecting, storing, and re-dispensing donated prescription drugs. Those same facilities may enjoy cost savings to the extent their patients might receive needed drugs or supplies on a more timely basis. Without such donations, some patients could return as sicker and costlier patients at a later date.

Participating facilities may recover a portion of costs by charging the patient a nominal handling fee for the preparation and dispensing of prescription drugs and supplies. The fee may not exceed the amount established by the DOH rule.

C. Government Sector Impact:

CS/SB 58 authorizes the creation of a direct-support organization (DSO) to provide assistance, funding, and promotional support for the Program's authorized activities. Sufficient funding and assistance provided by the DSO could relieve the DOH of negative fiscal impacts created by the bill. The Department of Health (DOH) may need to submit a legislative budget request for an indeterminate amount to support the Program, if the DSO is unsuccessful in collecting the necessary resources to operate the Program.

The DOH may experience an increase in workload and operational costs to administer the program. For the 2019-2020 fiscal year, the DOH estimated a cost of \$1,098,048 for the first year of implementation if the DOH serves as the central repository.⁶²

⁶² Email correspondence from the Department of Health (Feb. 7, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

Department of Health Estimated Costs for Fiscal Year 2019-20	
Component	Amount
Facility Costs <ul style="list-style-type: none"> Estimated need for a 5,000 square foot facility at current market rate of \$11.73 per square foot: \$703,800 Estimated Annual Utilities: \$5,000 	\$708,800
Personnel Costs <ul style="list-style-type: none"> 1.0 FTE – Senior Pharmacist: <ul style="list-style-type: none"> Rate: \$80,000; Benefits: \$34,400; Total: \$114,400 1.0 FTE –Administrative Assistant <ul style="list-style-type: none"> Rate: \$25,479; Benefits: \$10,956; Total: \$36,435 3.0 FTE –Pharmacy Technicians <ul style="list-style-type: none"> Rate: \$70,449; Benefits: \$30,293; Total: \$100,742 Standard Expense Package (5.0 FTE): <ul style="list-style-type: none"> Recurring Total: \$11,516 Nonrecurring Total: \$19,510 Human Resource Assessment (5.0 FTE): \$1,645 	\$284,248
Enhancements to Pharmacy Systems Enhancements to DOH Dispensing and Pharmaceutical Forms System (PFS) Inventory systems (nonrecurring cost).	\$70,000
Other Potential Costs Shipping of products to local repositories.	\$35,000
TOTAL OVERALL FIRST YEAR COSTS	\$1,098,048

The bill gives the DOH the option of contracting with a vendor to administer the Program. Several states with drug donation programs have contracted with third party vendors. The DOH has not provided an estimate of costs to contract with a third party vendor; however, it expects that these costs would be less compared to the DOH serving as the central repository.⁶³

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Cancer Drug Donation Program (CDDP) as previously described is not amended or incorporated into this proposed, broader drug donation program under the bill. The two programs would continue to run simultaneously and administered separately by the DOH and DBPR.

VIII. Statutes Affected:

This bill substantially amends section 252.36 of the Florida Statutes.

This bill creates section 465.1902 of the Florida Statutes.

⁶³ Email correspondence from the Department of Health (Feb. 11, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

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 October 15, 2019:

The CS makes a technical correction to the underlying bill by changing “centralized pharmacy” to “centralized repository” on lines 323-324.

- B. **Amendments:**

None.



533618

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
10/15/2019	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 324
and insert:
repository a summary of each intake collection form within 5
days

By Senator Book

32-00053-20

202058__

1 A bill to be entitled
 2 An act relating to the Prescription Drug Donation
 3 Repository Program; creating s. 465.1902, F.S.;
 4 providing a short title; defining terms; creating the
 5 Prescription Drug Donation Repository Program within
 6 the Department of Health; specifying the purpose of
 7 the program; authorizing the department to contract
 8 with a third-party vendor to administer the program;
 9 specifying entities that are eligible donors;
 10 providing criteria and procedures for eligible
 11 donations; prohibiting donations to specific patients;
 12 providing that certain prescription drugs eligible for
 13 return to stock must be credited to Medicaid and may
 14 not be donated under the program; prohibiting the
 15 donation of certain drugs; clarifying that a
 16 repository is not required to accept donations of
 17 prescription drugs or supplies; requiring inspection
 18 of donated prescription drugs and supplies by a
 19 licensed pharmacist; providing inspection, inventory,
 20 and storage requirements for centralized and local
 21 repositories; requiring a local repository to notify
 22 the centralized repository within a specified
 23 timeframe after receiving a donation of prescription
 24 drugs or supplies; authorizing the centralized
 25 repository to redistribute prescription drugs or
 26 supplies; authorizing a local repository to transfer
 27 prescription drugs or supplies to another local
 28 repository with authorization from the centralized
 29 repository; requiring a local repository to notify the

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

32-00053-20

202058__

30 department of its intent to participate in the
 31 program; providing notification requirements;
 32 providing a procedure for a local repository to
 33 withdraw from participation in the program; requiring
 34 the department to adopt rules regarding the
 35 disposition of prescription drugs and supplies of a
 36 withdrawing local repository; specifying conditions
 37 for dispensing donated prescription drugs and supplies
 38 to eligible patients; providing intake collection form
 39 requirements; requiring a local repository to issue an
 40 eligible patient who completes an intake collection
 41 form a program identification card; prohibiting the
 42 sale of donated prescription drugs and supplies under
 43 the program; authorizing a repository to charge the
 44 patient a nominal handling fee for the preparation and
 45 dispensing of prescription drugs or supplies under the
 46 program; requiring repositories to establish a
 47 protocol for notifying recipients of a prescription
 48 drug recall; providing for destruction of donated
 49 prescription drugs under certain circumstances;
 50 providing recordkeeping requirements; requiring the
 51 centralized repository to submit annual reports to the
 52 department; requiring the department or contractor to
 53 establish, maintain, and publish a registry of
 54 participating local repositories and available donated
 55 prescription drugs and supplies; requiring the
 56 department to publish certain information and forms on
 57 its website; providing immunity from civil and
 58 criminal liability and from professional disciplinary

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59 action for participants under certain circumstances;
 60 providing immunity to pharmaceutical manufacturers,
 61 under certain circumstances, from any claim or injury
 62 arising from the donation of any prescription drug or
 63 supply under the program; requiring dispensers to
 64 provide certain notice to patients; authorizing the
 65 department to establish a direct-support organization
 66 to provide assistance, funding, and promotional
 67 support for program activities; providing
 68 organizational requirements for a direct-support
 69 organization; specifying direct-support organization
 70 purposes and objectives; prohibiting the direct-
 71 support organization from lobbying; specifying that
 72 the direct-support organization is not a lobbying
 73 firm; prohibiting the direct-support organization from
 74 possessing prescription drugs on behalf of the
 75 program; providing limitations on expenditures of such
 76 direct-support organizations; specifying that the
 77 direct-support organization must operate under
 78 contract with the department; specifying required
 79 contract terms; providing for the direct-support
 80 organization board of directors; specifying the
 81 board's membership requirements; specifying
 82 requirements for and requiring the department to adopt
 83 rules relating to a direct-support organization's use
 84 of department property; specifying requirements for
 85 the deposit and use of funds by the direct-support
 86 organization; providing for annual audits of a direct-
 87 support organization; providing for future legislative

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88 review and repeal of provisions relating to the
 89 direct-support organization; requiring the department
 90 to adopt rules; amending s. 252.36, F.S.; authorizing
 91 the Governor to waive program patient eligibility
 92 requirements during a declared state of emergency;
 93 providing an effective date.
 94
 95 Be It Enacted by the Legislature of the State of Florida:
 96
 97 Section 1. Section 465.1902, Florida Statutes, is created
 98 to read:
 99 465.1902 Prescription Drug Donation Repository Program.-
 100 (1) SHORT TITLE.-This section may be cited as the
 101 "Prescription Drug Donation Repository Program Act."
 102 (2) DEFINITIONS.-As used in this section, the term:
 103 (a) "Centralized repository" means a distributor permitted
 104 under chapter 499 who is approved by the department or the
 105 contractor to accept, inspect, inventory, and distribute donated
 106 drugs and supplies under this section.
 107 (b) "Closed drug delivery system" means a system in which
 108 the actual control of the unit-dose medication package is
 109 maintained by the facility, rather than by the individual
 110 patient.
 111 (c) "Contractor" means the third-party vendor approved by
 112 the department to implement and administer the program as
 113 authorized in subsection (4).
 114 (d) "Controlled substance" means any substance listed under
 115 Schedule II, Schedule III, Schedule IV, or Schedule V of s.
 116 893.03.

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- 117 (e) "Direct-support organization" means the entity created
 118 under subsection (15).
- 119 (f) "Dispenser" means a health care practitioner who,
 120 within the scope of his or her practice act, is authorized to
 121 dispense medicinal drugs and who does so under this section.
- 122 (g) "Donor" means an entity specified in subsection (5).
- 123 (h) "Eligible patient" means a resident of this state who
 124 is indigent, uninsured, or underinsured and who has a valid
 125 prescription for a prescription drug or supply that may be
 126 dispensed under the program.
- 127 (i) "Free clinic" means a clinic that delivers only medical
 128 diagnostic services or nonsurgical medical treatment free of
 129 charge to low-income recipients.
- 130 (j) "Health care practitioner" or "practitioner" means a
 131 practitioner licensed under this chapter, chapter 458, chapter
 132 459, chapter 461, chapter 463, chapter 464, or chapter 466.
- 133 (k) "Indigent" means an individual whose family income for
 134 the 12 months preceding the determination of income is below 200
 135 percent of the federal poverty level as defined by the most
 136 recently revised poverty income guidelines published by the
 137 United States Department of Health and Human Services.
- 138 (l) "Local repository" means a health care practitioner's
 139 office, a pharmacy, a hospital with a closed drug delivery
 140 system, a nursing home facility with a closed drug delivery
 141 system, or a free clinic or nonprofit health clinic that is
 142 licensed or permitted to dispense medicinal drugs in this state.
- 143 (m) "Nonprofit health clinic" means a nonprofit legal
 144 entity that provides medical care to patients who are indigent,
 145 uninsured, or underinsured. The term includes, but is not

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- 146 limited to, a federally qualified health center as defined in 42
 147 U.S.C. s. 1396d(1)(2)(B) and a rural health clinic as defined in
 148 42 U.S.C. s. 1396d(1)(1).
- 149 (n) "Nursing home facility" has the same meaning as in s.
 150 400.021.
- 151 (o) "Prescriber" means a health care practitioner who,
 152 within the scope of his or her practice act, is authorized to
 153 prescribe medicinal drugs.
- 154 (p) "Prescription drug" has the same meaning as the term
 155 "medicinal drugs" or "drugs," as those terms are defined in s.
 156 465.003(8), but does not include controlled substances or cancer
 157 drugs donated under s. 499.029.
- 158 (q) "Program" means the Prescription Drug Donation
 159 Repository Program created by this section.
- 160 (r) "Supplies" means any supply used in the administration
 161 of a prescription drug.
- 162 (s) "Tamper-evident packaging" means a package that has one
 163 or more indicators or barriers to entry which, if breached or
 164 missing, can reasonably be expected to provide visible evidence
 165 to consumers that tampering has occurred.
- 166 (t) "Underinsured" means a person who has third-party
 167 insurance or is eligible to receive prescription drugs or
 168 supplies through the Medicaid program or any other prescription
 169 drug program funded in whole or in part by the Federal
 170 Government, but who has exhausted these benefits or does not
 171 have prescription drug coverage for the drug prescribed.
- 172 (u) "Uninsured" means a person who has no third-party
 173 insurance and is not eligible to receive prescription drugs or
 174 supplies through the Medicaid program or any other prescription

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175 drug program funded in whole or in part by the Federal
 176 Government.

177 (3) PRESCRIPTION DRUG DONATION REPOSITORY PROGRAM;
 178 CREATION; PURPOSE.—The Prescription Drug Donation Repository
 179 Program is created within the department for the purpose of
 180 authorizing and facilitating the donation of prescription drugs
 181 and supplies to eligible patients.

182 (4) PROGRAM IMPLEMENTATION; ADMINISTRATION.—The department
 183 may contract with a third-party vendor to administer the
 184 program.

185 (5) DONOR ELIGIBILITY.—The centralized repository or a
 186 local repository may accept a donation of a prescription drug or
 187 supply only from:

188 (a) Nursing home facilities with closed drug delivery
 189 systems.

190 (b) Hospices that have maintained control of a patient's
 191 prescription drugs.

192 (c) Hospitals with closed drug delivery systems.

193 (d) Pharmacies.

194 (e) Drug manufacturers or wholesale distributors.

195 (f) Medical device manufacturers or suppliers.

196 (g) Prescribers who receive prescription drugs or supplies
 197 directly from a drug manufacturer, wholesale distributor, or
 198 pharmacy.

199 (6) PRESCRIPTION DRUGS AND SUPPLIES ELIGIBLE FOR DONATION;
 200 DONATION REQUIREMENTS; PROHIBITED DONATIONS.—

201 (a) Only prescription drugs and supplies that have been
 202 approved for medical use in the United States and that meet the
 203 criteria for donation established by this section may be

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204 accepted for donation under the program. Donations must be made
 205 on the premises of the centralized repository or a local
 206 repository to a person designated by the repository. A drop box
 207 may not be used to accept donations.

208 (b) The centralized repository or a local repository may
 209 accept a prescription drug only if:

210 1. The drug is in its original sealed and tamper-evident
 211 packaging. Single-unit-dose drugs may be accepted if the single-
 212 unit-dose packaging is unopened.

213 2. The drug requires storage at normal room temperature per
 214 the manufacturer or the United States Pharmacopeia.

215 3. The drug has been stored according to manufacturer or
 216 United States Pharmacopeia storage requirements.

217 4. The drug does not have any physical signs of tampering
 218 or adulteration and there is no reason to believe that the drug
 219 is adulterated.

220 5. The packaging does not have any physical signs of
 221 tampering, misbranding, deterioration, compromised integrity, or
 222 adulteration.

223 6. The packaging indicates the lot number and expiration
 224 date of the drug. If the lot number is not retrievable, all
 225 specified medications must be destroyed in the event of a
 226 recall.

227 7. The drug has an expiration date that is more than 3
 228 months after the date that the drug was donated.

229 (c) The centralized repository or a local repository may
 230 accept supplies only if they are in their original, unopened,
 231 sealed packaging and have not been tampered with or misbranded.

232 (d) Prescription drugs or supplies may not be donated to a

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specific patient.

(e) Prescription drugs billed to and paid for by Medicaid in long-term care facilities which are eligible for return to stock under federal Medicaid regulations must be credited to Medicaid and may not be donated under the program.

(f) Prescription drugs with an approved Federal Food and Drug Administration Risk Evaluation and Mitigation Strategy that includes Elements to Assure Safe Use are not eligible for donation under the program.

(g) This section does not require the centralized repository or a local repository to accept a donation of prescription drugs or supplies.

(7) INSPECTION AND STORAGE.—

(a) A licensed pharmacist employed by or under contract with the centralized repository or a local repository shall inspect donated prescription drugs and supplies to determine whether they meet the requirements of subsections (5) and (6).

(b) The inspecting pharmacist must sign an inspection record on a form prescribed by the department by rule which verifies that the prescription drugs and supplies meet the requirements of subsections (5) and (6) and must attach the record to the inventory required by paragraph (d). A local repository that receives drugs and supplies from the centralized repository is not required to reinspect them.

(c) The centralized repository and local repositories shall store donated prescription drugs and supplies in a secure storage area under the environmental conditions specified by the manufacturer or the United States Pharmacopeia for the respective prescription drugs or supplies. Donated prescription

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drugs and supplies may not be stored with other inventory. A local repository shall quarantine donated prescription drugs or supplies until they are inspected and approved for dispensing under this section.

(d) The centralized repository and local repositories shall maintain an inventory of all donated prescription drugs or supplies. Such inventory at local repositories must be recorded on a form prescribed by the department by rule.

(e) A local repository shall notify the centralized repository within 5 days after receipt of any donation of prescription drugs or supplies to the program. The notification must be on a form prescribed by the department by rule.

(f) The centralized repository may redistribute prescription drugs and supplies by transferring them to or from the centralized repository and a local repository, as needed. A local repository that receives donated prescription drugs or supplies may, with authorization from the centralized repository, distribute the prescription drugs or supplies to another local repository.

(8) PROGRAM PARTICIPATION.—

(a) A practitioner, pharmacy, facility, or clinic shall notify the department of its intent to participate in the program as a local repository before accepting or dispensing any prescription drugs or supplies pursuant to this section. The notification must be made on a form prescribed by the department by rule and must, at a minimum, include:

1. The name, street address, website, and telephone number of the intended local repository and any license or registration number issued by the state to the intended local repository,

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including the name of the issuing agency.

2. The name and telephone number of the pharmacist employed by or under contract with the intended local repository who is responsible for the inspection of donated prescription drugs and supplies.

3. A statement signed and dated by the responsible pharmacist which affirms that the intended local repository meets the eligibility requirements of this section.

(b) A local repository may withdraw from participation in the program at any time by providing written notice to the department or contractor, as appropriate, on a form prescribed by the department by rule. The department shall adopt rules addressing the disposition of prescription drugs and supplies in the possession of the withdrawing local repository.

(9) DISPENSING REQUIREMENTS; PROHIBITIONS.—

(a) Each eligible patient without a program identification card must submit an intake collection form to a local repository before receiving prescription drugs or supplies under the program. The department shall prescribe a form by rule, which must include at least all of the following:

1. The name, street address, and telephone number of the eligible patient.

2. The basis for eligibility, which must specify that the patient is indigent, uninsured, or underinsured.

3. A statement signed and dated by the eligible patient which affirms that he or she meets the eligibility requirements of this section.

(b) Upon receipt of a completed and signed intake collection form, the local repository shall issue him or her a

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program identification card, which is valid for 1 year after its date of issuance. The card must be in a form prescribed by the department by rule.

(c) The local repository shall send to the centralized pharmacy a summary of each intake collection form within 5 days after receiving it.

(d) A dispenser may dispense donated prescription drugs or supplies only to an eligible patient who has a program identification card or who has submitted a completed intake collection form.

(e) A dispenser shall inspect the donated prescription drugs or supplies before dispensing them.

(f) A dispenser may provide dispensing and consulting services to an eligible patient.

(g) Donated prescription drugs and supplies may not be sold or resold under the program.

(h) A dispenser of donated prescription drugs or supplies may not submit a claim or otherwise seek reimbursement from any public or private third-party payor for donated prescription drugs or supplies dispensed under this program. However, a repository may charge the patient a nominal handling fee, established by department rule, for the preparation and dispensing of prescription drugs or supplies under the program.

(10) RECALLED PRESCRIPTION DRUGS AND SUPPLIES.—

(a) The centralized repository and each local repository shall establish and follow a protocol for notifying recipients in the event of a prescription drug recall.

(b) Local repositories shall destroy all recalled or expired prescription drugs and all prescription drugs that are

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not suitable for dispensing in the repository. Local repositories must complete a destruction information form for all such drugs, in accordance with department rule.

(11) RECORDKEEPING.—

(a) Local repositories shall maintain records of prescription drugs and supplies that are accepted, donated, dispensed, distributed, or destroyed under the program.

(b) All required records must be maintained in accordance with any applicable practice act. Local repositories shall submit these records quarterly to the centralized repository for data collection, and the centralized repository shall submit these records and the collected data in annual reports to the department.

(12) REGISTRIES; PUBLICATION OF FORMS.—

(a) The department or contractor shall establish and maintain a registry of all local repositories and of prescription drugs and supplies available under the program. The registry of local repositories must include each repository's name, address, website, and telephone number. The registry of available prescription drugs and supplies must include the name, strength, available quantity, and expiration date of the prescription drug or supplies and the name and contact information of each repository where such drug or supplies are available. The department shall publish the registry on its website.

(b) The department shall publish all forms required by this section on its website.

(13) IMMUNITY FROM LIABILITY, DISCIPLINARY ACTION.—

(a) Any donor of prescription drugs or supplies and any

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participant in the program who exercises reasonable care in donating, accepting, distributing, or dispensing prescription drugs or supplies under the program is immune from civil or criminal liability and from professional disciplinary action by the state for any injury, death, or loss to person or property relating to such activities.

(b) A pharmaceutical manufacturer who exercises reasonable care is not liable for any claim or injury arising from the donation of any prescription drug or supply under this section, including, but not limited to, liability for failure to transfer or communicate product or consumer information regarding the donated prescription drug, including its expiration date.

(14) NOTICE TO PATIENTS.—Before dispensing a donated prescription drug under the program, the dispenser must provide written notification to the eligible patient or his or her legal representative, receipt of which must be acknowledged in writing, of all of the following information:

(a) The prescription drug was donated to the program.

(b) The donors and participants in the program are immune from civil or criminal liability or disciplinary action.

(c) The eligible patient is not required to pay for the prescription drug, but may be required to pay a nominal handling fee, which may not exceed the amount established by department rule.

(15) DIRECT-SUPPORT ORGANIZATION.—The department may establish a direct-support organization to provide assistance, funding, and promotional support for the activities authorized by this section.

(a) Entity organization.—The direct-support organization

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must operate in accordance with s. 20.058 and is:

1. A Florida corporation not for profit incorporated under chapter 617, exempted from filing fees, and approved by the Department of State.

2. Organized and operated to conduct programs and activities; raise funds and request and receive grants, gifts, and bequests of moneys; acquire, receive, hold, and invest, in its own name, securities, funds, objects of value, or other property, either real or personal; and make expenditures or provide funding to or for the direct or indirect benefit of the program.

(b) Purposes and objectives.—The purposes and objectives of the direct-support organization must be consistent with the goals of the department, in the best interest of the state, and in accordance with the adopted goals and the mission of the department.

(c) Prohibition against lobbying.—The direct-support organization is not considered a lobbying firm, as that term is defined in s. 11.045(1). All expenditures of the direct-support organization must be directly related to program administration within the requirements of this section. Funds of the direct-support organization may not be used for the purpose of lobbying, as that term is defined in s. 11.045(1).

(d) Possession of prescription drugs.—The direct-support organization may not possess any prescription drugs on behalf of the program.

(e) Contract.—The direct-support organization shall operate under a written contract with the department.

1. The contract must require the direct-support

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organization to submit to the department, annually by August 1, the following information, which must be posted on the websites of the direct-support organization and the department:

a. The articles of incorporation and bylaws of the direct-support organization, as approved by the department.

b. A proposed annual budget for the approval of the department.

c. The code of ethics of the direct-support organization.

d. The statutory authority or executive order that created the direct-support organization.

e. A brief description of the direct-support organization's mission and any results obtained by the direct-support organization.

f. A brief description of the direct-support organization's annual plan for each of the next 3 fiscal years.

g. A copy of the direct-support organization's most recent federal Internal Revenue Service Return Organization Exempt from Income Tax form (Form 990).

h. Certification by the department that the direct-support organization is complying with the terms of the contract and operating in a manner consistent with the goals and purposes of the department and the best interest of the program and the state. Such certification must be made annually and reported in the official minutes of a meeting of the board of directors of the direct-support organization.

2. The contract must, at a minimum, provide for:

a. The reversion without penalty to the department, or to the state if the department ceases to exist, of all moneys and property held in trust by the direct-support organization for

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the benefit of the program if the direct-support organization ceases to exist or if the contract is terminated.

b. A disclosure of material provisions of the contract and the distinction between the department and the direct-support organization to appear on all promotional and fundraising publications.

c. A list of prescription drugs solicited by the direct-support organization for distribution to the centralized repository or a local repository.

(f) *Board of directors.*—The State Surgeon General shall appoint the board of directors, which must consist of at least 5 members, but not more than 15 members, who serve at his or her pleasure. The board must elect a chair from among its members. Board members must serve without compensation but may be entitled to reimbursement of travel and per diem expenses in accordance with s. 112.061, if funds are available for this purpose.

(g) *Use of property.*—The department may allow, without charge, appropriate use of fixed property, facilities, and personnel services of the department by the direct-support organization for purposes related to the program. For purposes of this paragraph, the term “personnel services” includes full-time or part-time personnel, as well as payroll processing services.

1. The department may prescribe any condition with which the direct-support organization must comply in order to use fixed property or facilities of the department.

2. The department may not allow the use of any fixed property or facilities of the department by the direct-support

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organization if the organization does not provide equal membership and employment opportunities to all persons regardless of race, color, religion, sex, age, or national origin.

3. The department shall adopt rules prescribing the procedures by which the direct-support organization is governed and any conditions with which a direct-support organization must comply to use property or facilities of the department.

(h) *Deposit of funds.*—Any moneys of the direct-support organization may be held in a separate depository account in the name of the organization and subject to the provisions of the organization’s contract with the department.

(i) *Use of funds.*—Funds designated for the direct-support organization must be used for the enhancement of program projects and in a manner consistent with that purpose. Any administrative costs of running and promoting the purposes of the organization or program must be paid by private funds.

(j) *Audit.*—The direct-support organization shall provide for an annual financial audit in accordance with s. 215.981.

(k) *Repeal.*—This subsection is repealed on October 1, 2025, unless reviewed and saved from repeal by the Legislature.

(16) *RULEMAKING.*—The department shall adopt rules necessary to administer this section. When applicable, the rules may provide for the use of electronic forms, recordkeeping, and meeting by teleconference.

Section 2. Paragraph (o) is added to subsection (5) of section 252.36, Florida Statutes, to read:

252.36 Emergency management powers of the Governor.—

(5) In addition to any other powers conferred upon the

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523 Governor by law, she or he may:

524 (o) Waive the patient eligibility requirements of s.

525 465.1902.

526 Section 3. This act shall take effect July 1, 2020.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Children, Families, and Elder Affairs, *Chair*
Appropriations
Appropriations Subcommittee on Education
Appropriations Subcommittee on Health and Human
Services
Health Policy
Rules

JOINT COMMITTEE:

Joint Legislative Budget Commission

SENATOR LAUREN BOOK

32nd District

August 19, 2019

Chair Gayle Harrell
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chair Harrell:

I respectfully request that **SB 58—Prescription Drug Repository Program** be placed on the agenda for the next Committee on Health Policy meeting.

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

Thank you,

A handwritten signature in cursive script that reads "Lauren Book".

Senator Lauren Book
Senate District 32

Cc: Allen Brown, Staff Director
Celia Georgiades, Administrative Assistant

REPLY TO:

- ☐ 967 Nob Hill Road, Plantation, Florida 33324 (954) 424-6674
- ☐ 202 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5032

Senate's Website: www.flsenate.gov

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE
APPEARANCE RECORD



10-15-19
Meeting Date

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

58
Bill Number (if applicable)

Topic DRUG RX DONATION

Amendment Barcode (if applicable)

Name DAWN STEWARD

Job Title Retired

Address 2130 Blossom Lane
Street

Phone 407-645-0273

Winter Park FL 32789
City State Zip

Email stu21300adcon

Speaking: ☐ For ☐ Against ☐ Information

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

Representing _____

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 100

INTRODUCER: Senator Harrell

SUBJECT: Dispensing Medicinal Drugs

DATE: October 14, 2019

REVISED: _____

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

I. Summary:

SB 100 amends s. 465.019, F.S., to authorize individuals licensed to prescribe medicinal drugs to dispense a 48-hour supply, rather than a 24-hour supply, of medicinal drugs to any patient of, or a patient discharged from, a hospital emergency department that operates a Class II or Class III institutional pharmacy with a community pharmacy permit from the Department of Health (DOH), under certain conditions.

The bill authorizes such individuals to dispense a 72-hour supply, rather than a 48-hour supply, during a declared state of emergency in the area, under certain conditions.

The bill has an effective date of July 1, 2020.

II. Present Situation:

Medicinal Prescribing and Dispensing Practitioners

There are several professions in Florida that have prescriptive authority at various levels, including:

- Allopathic physicians;
- Osteopathic physicians;
- Podiatrists;
- Dentists;
- Advanced practice registered nurses;¹
- Physician assistants;² and

¹ See s. 464.012(3)(a), F.S.

² See ss. 458.347(4)(e)4. and 459.022(4)(e)4., F.S.

- Pharmacists.³

A person may not dispense medicinal drugs unless licensed as a pharmacist, except that a practitioner authorized by law to prescribe drugs may dispense medicinal drugs to his or her patients in the regular course of her or his practice.⁴ A practitioner, who dispenses medicinal drugs for human consumption for a fee or remuneration of any kind, whether directly or indirectly, must:

- Register with her or his professional licensing board as a dispensing practitioner and pay a board-established fee at the time of such registration and upon each renewal of his or her license;
- Comply with, and be subject to, all laws and rules applicable to pharmacists and pharmacies, including, but not limited to, chs. 456, 499 and 893, F.S., and all applicable federal laws and federal regulations; and
- Give each patient a written prescription and, orally or in writing, advise the patient that the prescription may be filled in the practitioner's office or at any pharmacy, before dispensing any drug.⁵

Pharmacy

The practice of pharmacy and the licensure of pharmacies are regulated by ch. 465, F.S. The "practice of the profession of pharmacy" includes:

- Compounding, dispensing, and consulting the consumer concerning the contents, therapeutic values, and uses of any medicinal (prescription)⁶ drug; and
- Other pharmaceutical services.^{7, 8}

The Board of Pharmacy

The Board of Pharmacy (board) is created within the DOH and is authorized to make rules to regulate the practice of professional pharmacy in pharmacies meeting minimum requirements for safe practice.⁹ All pharmacies must obtain a permit before operating, unless exempt by law. This is true whether opening a new establishment or simply changing locations or owners.¹⁰

³ See s. 465.186, F.S., and Fla. Admin. Code R. 64B8-36.001 (2019).

⁴ Section 465.0276, F.S.

⁵ Section 465.0276(2), F.S.

⁶ Under s. 465.003(8), F.S., "medicinal drugs" means substances commonly known as "prescription" or "legend" drugs required by law to be dispensed by prescription only.

⁷ Section 465.003(13), F.S.

⁸ In the context of pharmacy practice, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider as licensed under chs. 458, 459, 461, or 466, F.S., or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. The "practice of the profession of pharmacy" also includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, expressly permits a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients, and includes the administration of vaccines to adults. See s. 465.003(13), F.S.

⁹ Sections 465.002 and 465.0155, F.S.

¹⁰ See Fla. Admin. Code R. 64B16-28.100(1)(2019).

The Practice of Pharmacy

There are seven types of pharmacies eligible for various operating permits issued by the DOH:

- Community pharmacy;¹¹
- Institutional pharmacy;¹²
- Nuclear pharmacy;¹³
- Special pharmacy;¹⁴
- Internet pharmacy;¹⁵
- Non-resident sterile compounding pharmacy;¹⁶ and
- Special sterile compounding pharmacy.¹⁷

Institutional Pharmacies

An “institutional pharmacy” includes any pharmacy located in a health care institution, which includes a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medicinal drugs are compounded, dispensed, stored, or sold.¹⁸ Institutional pharmacy permits are required for any pharmacy located in any health care institution.¹⁹

All institutional pharmacies must designate a consultant pharmacist²⁰ who is responsible for maintaining all drug records required by law, and for establishing drug handling procedures for the safe handling and storage of drugs. The consultant pharmacist may also be responsible for ordering and evaluating any laboratory or clinical tests when such tests are necessary for the proper performance of his or her responsibilities.²¹ Such laboratory tests or clinical tests may be ordered only with regard to patients residing in a nursing home, and then only when authorized by the facility’s medical director. The consultant pharmacist must complete additional training

¹¹ 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. *See* ss. 465.003(11)(a)1. and 465.018, F.S.

¹² *See* ss. 465.003(11)(a)2. and 465.019, F.S.

¹³ The term “nuclear pharmacy” includes every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold, but does not include hospitals licensed under ch. 395, F.S., or the nuclear medicine facilities of such hospitals. *See* ss. 465.003(11)(a)3. and 465.0193, F.S.

¹⁴ The term “special pharmacy” includes every location where medicinal drugs are compounded, dispensed, stored, or sold if such locations are not otherwise defined by law. *See* ss. 465.003(11)(a)4. and 465.0196, F.S.

¹⁵ The term “internet pharmacy” includes locations not otherwise licensed or issued a permit under ch. 465, F.S., whether or not in Florida, which use the Internet to communicate with or obtain information from consumers in this state and use such communication or information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state. *See* ss. 465.003(11)(a)5. and 465.0197, F.S.

¹⁶ The term “nonresident sterile compounding pharmacy” includes a pharmacy that ships, mails, delivers, or dispenses, in any manner, a compounded sterile product into Florida, and a nonresident pharmacy registered under s. 465.0156, F.S., or an outsourcing facility, must hold a nonresident sterile compounding permit. *See* s. 465.0158, F.S.

¹⁷ *See* Fla. Admin. Code R. 64B16-28.100 and 64B16-28.802 (2019). An outsourcing facility is considered a pharmacy and must hold a special sterile compounding permit if it engages in sterile compounding.

¹⁸ Section 465.003(11)(a)2., F.S.

¹⁹ *See* Fla. Admin. Code R. 64B16-28.100(3) (2019).

²⁰ *See* ss. 465.003(11) and 465.0125, F.S.

²¹ *Id.*

and demonstrate additional qualifications in the practice of institutional pharmacy, as required by the board, and be licensed as a registered pharmacist.^{22, 23}

Currently there are four types of institutional pharmacy permits issued by the board to institutional pharmacies: Institutional Class I, Class II, Modified Class II, and Class III.²⁴

Institutional Class I Pharmacy

A Class I institutional pharmacy is an institutional pharmacy in which all medicinal drugs are administered from individual prescription containers to an individual patient and in which medicinal drugs are not dispensed on the premises, except that licensed nursing homes²⁵ may purchase medical oxygen for administration to residents.²⁶

Institutional Class II Pharmacy

A Class II institutional pharmacy is a pharmacy that employs the services of a registered pharmacist or pharmacists who, in practicing institutional pharmacy, provide dispensing and consulting services on the premises to patients of the institution, for use on the premises of the institution.²⁷ A facility's Class II institutional pharmacy is required to be open sufficient hours to meet the needs of the facility.²⁸ The consultant pharmacist of record is responsible for establishing a written policy and procedure manual.²⁹ An institutional Class II pharmacy may elect to participate in the Cancer Drug Donation Program within the Department of Business and Professional Regulation.³⁰

Modified Institutional Class II Pharmacy Permits

Modified Institutional Class II pharmacies are those institutional pharmacies in short-term, primary care treatment centers that meet all the requirements for a Class II permit, except space and equipment requirements.³¹ Modified Class II Institutional pharmacies are designated as Type A, Type B, and Type C according to the specialized type of the medicinal drug delivery

²² Section 465.0125, F.S.

²³ As required by Fla. Admin. Code R. 64B16-28.501(1), (2), and (3) (2019), the consultant pharmacist must also "conduct Drug Regimen Reviews required by Federal or State law, inspect the facility and prepare a written report to be filed at the permitted facility at least monthly, . . . monitor the facility system for providing medication administration records and physician order sheets to ensure that the most current record of medications is available for the monthly drug regimen review, and may utilize additional consultant pharmacists to assist in this review and in the monthly facility inspection." A licensed consultant pharmacist may "remotely access a facility or pharmacy's electronic database from outside the facility or pharmacy to conduct any services additional or supplemental to regular drug regimen reviews, subject to the pharmacy or facility establishing policies and procedures to ensure the security and privacy of confidential patient records, including compliance with applicable Federal HIPAA regulations." The board must be notified in writing within ten days of any change in the consultant pharmacist of record, pursuant to Fla. Admin. Code R. 64B16-28.100(3)(b) (2019).

²⁴ Section 465.019, F.S.

²⁵ See part II, ch. 400, F.S., relating to nursing homes.

²⁶ Section 465.019(2)(a), F.S.

²⁷ See s. 565.019(2)(b), F.S. Exceptions apply when there is a state of emergency and for single doses of a drug ordered by physicians under limited circumstances.

²⁸ See Fla. Admin. Code R. 64B16-28.603 (2019).

²⁹ See s. 465.019(5), F.S.

³⁰ See s. 499.029, F.S., relating to the Cancer Drug Donation Program Act.

³¹ See s. 465.019(2)(c), F.S.

system utilized at the facility, either a patient-specific or bulk drug system, and the quantity of the medicinal drug formulary at the facility.³²

All Modified Class II institutional pharmacies must be under the control and supervision of a certified consultant pharmacist. The consultant pharmacist of record is responsible for developing and maintaining a current policy and procedure manual. The permittee must make available the policy and procedure manual to the appropriate state or federal agencies upon inspection.³³

Institutional Class III Pharmacies

Class III institutional pharmacies are those pharmacies, including central distribution facilities, affiliated with a hospital that provide the same services that are authorized by a Class II institutional pharmacy permit. Class III institutional pharmacies may also:

- Dispense, distribute, compound, and fill prescriptions for medicinal drugs;
- Prepare prepackaged drug products;
- Conduct other pharmaceutical services for the affiliated hospital and for entities under common control that are each permitted under ch. 465, F.S., to possess medicinal drugs; and
- Provide the services in Class I institutional pharmacies, Class II institutional pharmacies, and Modified Class II institutional pharmacies which hold an active health care clinic establishment permit.^{34,35}

A Class III institutional pharmacy must also maintain policies and procedures addressing the following:

- The consultant pharmacist responsible for pharmaceutical services;
- Safe practices for the preparation, dispensing, prepackaging, distribution, and transportation of medicinal drugs and prepackaged drug products;
- Recordkeeping to monitor the movement, distribution, and transportation of medicinal drugs and prepackaged drug products;
- Recordkeeping of pharmacy staff responsible for each step in the preparation, dispensing, prepackaging, transportation, and distribution of medicinal drugs and prepackaged drug products; and

³² See Fla. Admin. Code R. 64B16-28.702(2) (2019). Modified Class II Institutional Pharmacies provide the following pharmacy services: (1) Type “A” Modified Class II Institutional Pharmacies provide pharmacy services in a facility which has a formulary of not more than 15 medicinal drugs, excluding those medicinal drugs contained in an emergency box, and in which the medicinal drugs are stored in bulk and in which the consultant pharmacist provides on-site consultations not less than once every month, unless otherwise directed by the board after review of the policy and procedure manual; (2) Type “B” Modified Class II Institutional Pharmacies provide pharmacy services in a facility in which medicinal drugs are stored in the facility in patient specific form and in bulk form and which has an expanded drug formulary, and in which the consultant pharmacist provides on-site consultations not less than once per month, unless otherwise directed by the board after review of the policy and procedure manual; and (3) Type “C” Modified Class II Institutional Pharmacies provide pharmacy services in a facility in which medicinal drugs are stored in the facility in patient specific form and which has an expanded drug formulary, and in which the consultant pharmacist provides onsite consultations not less than once per month, unless otherwise directed by the board after review of the policy and procedure manual.

³³ See Florida Board of Pharmacy, *Institutional Pharmacy Permit* <http://floridaspharmacy.gov/licensing/institutional-pharmacy-permit/> (last visited Oct. 3, 2019).

³⁴ Section 465.019(2)(d)1., F.S.

³⁵ See s. 499.01(2)(r), F.S.

- Medicinal drugs and prepackaged drug products that may not be safely distributed among Class III institutional pharmacies.³⁶

Institutional Pharmacies – Dispensing Medicinal Drugs

Class II and Class III institutional pharmacies are permitted to dispense medicinal drugs to outpatients only when that institution has been issued a community pharmacy permit from the DOH.³⁷ An individual licensed to prescribe medicinal drugs may dispense up to a 24-hour supply of a medicinal drug to any patient of an emergency department of a hospital that operates a Class II or Class III institutional pharmacy, provided the physician treating the patient in such hospital's emergency department determines the following:

- The medicinal drug is warranted; and
- Community pharmacy services are not readily accessible, geographically or otherwise, to the patient.³⁸

Such dispensing from the emergency department must be in accordance with the procedures of the hospital. For any such patient for whom a medicinal drug is determined to be warranted by the treating emergency department physician for a period to exceed 24 hours, an individual licensed to prescribe such drug must dispense a 24-hour supply of such drug to the patient and must provide the patient with a prescription for the drug for use after the initial 24-hour period.³⁹ The board is authorized to adopt rules necessary to carry out these provisions.

III. Effect of Proposed Changes:

The bill permits an individual licensed to prescribe medicinal drugs to dispense up to a 48-hour supply, rather than 24-hour supply, of medicinal drugs to any patient of, or a patient discharged from, a hospital emergency department that operates a Class II or Class III institutional pharmacy with a community pharmacy permit from the DOH, provided that the emergency department physician treating the patient, or a physician treating a discharged patient, determines that:

- The medicinal drug is warranted; and
- Community pharmacy services are not readily accessible to the patient, geographically or otherwise.

If the dispensing of a medicinal drug to a patient is determined to be warranted by the treating emergency department physician, or a physician treating a discharged patient, for a period of longer than 48 hours, the individual licensed to prescribe the drug must dispense a 48-hour supply to the patient and must provide the patient with a prescription for the drug for use after the initial 48 hours.

The bill also authorizes individuals licensed to prescribe medicinal drugs, under the conditions described above, to dispense a 72-hour supply, rather than a 48-hour supply, during a declared state of emergency in the area. The dispensing of a 72-hour supply is subject to the same

³⁶ Section 465.019(2)(d)2., F.S.

³⁷ See s. 465.019, F.S., which prohibits a Class I institutional pharmacy from dispensing medicinal drugs.

³⁸ Section 465.019(4), F.S.

³⁹ *Id.*

conditions provided in the bill for dispensing a 48-hour supply to any patient of, or patient discharged from, a hospital emergency department that operates a Class II or Class III institutional pharmacy with a community pharmacy permit from the DOH.

The bill has an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 465.019 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

None.

B. Amendments:

None.

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

By Senator Harrell

25-00202-20

2020100__

A bill to be entitled

An act relating to dispensing medicinal drugs; amending s. 465.019, F.S.; authorizing individuals licensed to prescribe medicinal drugs to dispense a 48-hour supply, rather than a 24-hour supply, of such drugs to any patient, including a discharged patient, under certain circumstances; authorizing such individuals to dispense a 72-hour supply if a state of emergency has been declared in the area; authorizing such individuals to provide prescriptions for an additional supply of such drugs; providing an effective date.

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

Section 1. Subsection (4) of section 465.019, Florida Statutes, is amended to read:

465.019 Institutional pharmacies; permits.—

(4) (a) Medicinal drugs shall be dispensed in an institutional pharmacy to outpatients only when that institution has secured a community pharmacy permit from the department. However, an individual licensed to prescribe medicinal drugs in this state may dispense up to a 48-hour 24-hour supply of a medicinal drug to any patient of, or patient discharged from, an emergency department of a hospital that operates a Class II or Class III institutional pharmacy, provided that the physician who is treating the patient in such hospital's emergency department, or who is treating the discharged patient, determines that the medicinal drug is warranted and that

Page 1 of 3

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

25-00202-20

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community pharmacy services are not readily accessible, geographically or otherwise, to the patient. Such dispensing from the emergency department to any patient, including a discharged patient, must be in accordance with the procedures of the hospital. For any such patient for whom a medicinal drug is warranted for a period to exceed 48 24 hours, an individual licensed to prescribe such drug must dispense a 48-hour 24-hour supply of such drug to the patient and must provide the patient with a prescription for such drug for use after the initial 48-hour 24-hour period.

(b) Notwithstanding paragraph (a), if a state of emergency has been declared for an area of the state pursuant to s. 252.36, an individual licensed to prescribe medicinal drugs in this state may dispense up to a 72-hour supply of a medicinal drug to any patient of, or patient discharged from, an emergency department of a hospital located in that area which operates a Class II or Class III institutional pharmacy, provided that the physician who is treating the patient in such hospital's emergency department, or who is treating the discharged patient, determines that the medicinal drug is warranted and that community pharmacy services are not readily accessible, geographically or otherwise, to the patient. Such dispensing from the emergency department to any patient, including a discharged patient, must be in accordance with the procedures of the hospital. For any such patient for whom a medicinal drug is warranted for a period to exceed 72 hours, an individual licensed to prescribe such drug shall dispense a 72-hour supply of such drug to the patient and shall provide the patient with a prescription for such drug for use after the initial 72-hour

Page 2 of 3

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59 period.60 (c) The board may adopt rules ~~necessary~~ to implement ~~carry~~
61 ~~out the provisions of~~ this subsection.

62 Section 2. This act shall take effect July 1, 2020.

THE FLORIDA SENATE
APPEARANCE RECORD

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

October 15, 2019

Meeting Date

SB 100

Bill Number (if applicable)

Topic Dispensing Medicinal Drugs

Amendment Barcode (if applicable)

Name Dorene Barker

Job Title Associate State Director for Advocacy

Address 200 West College Avenue

Phone 850 228-6387

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32301

Email dobarker@aarp

City

State

Zip

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

10/15/2019

Meeting Date

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

SB 100

Bill Number (if applicable)

Topic DISPENSING MEDICINAL DRUGS

Amendment Barcode (if applicable)

Name CESAR GRAJALES

Job Title DIRECTOR OF COALITIONS

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TALLAHASSEE

City

FL.

State

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Zip

Email cgrajales@belibne.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AMERICANS FOR PROSPERITY

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 230

INTRODUCER: Health Policy Committee and Senator Harrell

SUBJECT: Department of Health

DATE: October 16, 2019

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	Fav/CS
2.			AP	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 230 updates numerous provisions relating to health care practitioners and facilities regulated by the Department of Health (DOH), Division of Medical Quality Assurance (MQA). The bill:

- Substitutes the term “human immunodeficiency virus” (HIV) in place of “acquired immune deficiency syndrome” (AIDS) to broaden the scope of the DOH’s regional patient care networks for persons with AIDS to also include persons with HIV;
- Grants rulemaking authority to the DOH for responsibilities relating to maximizing the use of existing programs and coordinating stakeholders and resources to develop a state strategic plan, including the process of selecting physicians under the Conrad 30 Waiver Program;
- Modifies the DOH’s rule-making authority pertaining to minimal standards governing ambulance and emergency medical services vehicle equipment, supplies, design, and construction;
- Revises the DOH’s health care practitioner licensing provisions to permit the DOH to issue a temporary license, that expires in 60 days, instead of 30 days, to a non-resident or non-citizen physician who has accepted a residency, internship, or fellowship in Florida and has not yet received a social security number;
- Authorizes the DOH to issue medical faculty certificates, without examination, to full-time faculty at Nova Southeastern University or Lake Erie College of Osteopathic Medicine;
- Requires the applicant’s date of birth on health care professional licensure applications;
- Repeals the requirement that the Board of Medicine (BOM) conduct a review of organizations that board-certify physicians in dermatology;
- Updates the osteopathic internship and residency accrediting agencies to include the Accreditation Council for Graduate Medical Education (ACGME);
- Deregulates Registered Chiropractic Assistants (RCAs);

- Extends the requirement for the Florida Center for Nursing (FCN) to provide an implementation study and annual report on the availability of nursing programs and production of quality nurses to the Governor, the President of the Senate, and the Speaker of the House of Representatives until January 30, 2025;
- Grants rulemaking authority to the Board of Nursing (BON) to establish standards of practice, including discipline and standards of practice for certified nursing assistants (CNA);
- Recognizes CNA certification in a U.S. territory or the District of Columbia for certification in Florida and eliminates the element of intent for violations of the practice act by CNAs;
- Defines the supplemental general dentistry education required for dental licensure applicants who have not graduated from a dental school accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA), to exclude education in an advanced dental specialty;
- Repeals the requirement for Florida dentists and dental hygienists to grade dental and dental hygienist licensure examinations;
- Revives, reenacts, and amends statutory provisions relating to health access dental licenses, notwithstanding their repeal on January 1, 2020;
- Requires dentists and dental hygienists to report adverse incidents to the Board of Dentistry (BOD) and gives the BOD rule making authority;
- Authorizes an employee or independent contractor of a dental laboratory to engage in onsite consultation with a licensed dentist during a dental procedure and requires a dental laboratory to be inspected at least biennially;
- Requires an athletic trainer to work within his or her scope of practice as defined by the Board of Athletic Trainers (BOAT) and revises the educational and internship requirements for licensure;
- Requires the DOH to issue a single prosthetist-orthotist license to qualified applicants and establishes the educational requirements for dual registration;
- Revises massage therapy licensure requirements to:
 - Eliminate massage apprenticeships as a path to licensure by 2023; and
 - Require passage of a Board of Massage Therapy (BMT) specified national examination;
- Revises the definition of a massage therapy “apprentice” to include only those persons approved by the BMT to study colonic irrigation under a licensed massage therapist;
- Updates the name of the accreditation body for psychology programs and revises the requirements for psychology licensure;
- Limits the Board of Clinical Social Work, Marriage and Family Therapists, and Mental Health Counseling to the issuance of only one additional internship registration;
- Revises the licensure requirements for Marriage and Family Therapists and Licensed Mental Health Counselors; and
- Deletes obsolete language and makes technical and conforming changes.

The bill has an insignificant negative impact on state revenues and expenditures, which can be absorbed within existing resources of the DOH.

The bill has an effective date of July 1, 2020.

II. Present Situation:

Human Immunodeficiency Virus (HIV)

Human immunodeficiency virus (HIV)¹ is a virus spread through certain body fluids that attacks the body's immune system, specifically the CD4 cells, often called T cells. Over time, HIV can destroy so many of these cells that the body cannot fight off infections and disease. Opportunistic infections or cancers take advantage of a very weak immune system, which can lead to acquired immune deficiency syndrome (AIDS).²

Currently there is no effective cure for a person infected with HIV, but with proper medical care, HIV can be controlled. The medicines used to treat HIV are antiretroviral drugs. If persons with HIV receive prescribed antiretroviral therapy (ART), their viral load (the amount of the HIV in their blood) can become undetectable.³

When people get the HIV and do not receive treatment, they will typically progress through three stages of disease. ART helps people at all stages of the disease. Treatment can slow or prevent the progression from one stage to the next.

Acquired Immunodeficiency Syndrome (AIDS)

AIDS is the most severe phase of an HIV infection. Persons with AIDS have such badly damaged immune systems that they get an increasing number of severe illnesses, called opportunistic infections. Without treatment, persons with AIDS typically survive about three years. Common symptoms of AIDS include:

- Chills;
- Fever;
- Sweats;
- Swollen lymph glands;
- Weakness; and
- Weight loss.

Florida Aids Legislation

In 1988 the Florida legislature enacted the predecessor of s. 381.0042, F.S., declaring AIDS the nation's and state's number one public health problem, noting that there were over 59,000 known cases in the U.S. and 4,226 in Florida.⁴

Section 381.0042, F.S., authorizes the DOH to establish AIDS patient care networks in each region of the state where the number of cases of AIDS and other human immunodeficiency virus infections justifies the establishment of cost-effective regional patient care networks. The

¹ Center for Disease Control and Prevention. HIV, *About HIV/AIDS*, available at: <https://www.cdc.gov/hiv/basics/whatishiv.html> (last visited Oct. 10, 2019).

² Center for Disease Control and Prevention. HIV, *About HIV/AIDS*, available at: <https://www.cdc.gov/hiv/basics/whatishiv.html> (last visited Oct. 10, 2019).

³ Center for Disease Control and Prevention. HIV, *About HIV/AIDS*, available at: <https://www.cdc.gov/hiv/basics/whatishiv.html> (last visited Oct. 10, 2019).

⁴ CS/HB 1519, Bill Analysis, May 25, 1988 on file with the Senate Health Policy Committee

networks are to be delineated by DOH department rule which must take into account natural trade areas and centers of medical excellence that specialize in the treatment of AIDS, as well as available federal, state, and other funds.

Each patient care network must include representation of the following:

- Persons with HIV;
- Health care providers;
- Business interests;
- The DOH, including its county health departments and other possible agency resources; and
- Local government units.

Each network must plan for the care and treatment of persons with AIDS, and AIDS related complex, in a cost-effective, dignified manner that emphasizes outpatient and home care. Once each year, each network must make its recommendations concerning the needs for patient care to the DOH.

Emergency Medical Transport Services

In 1973, the Florida Legislature passed and enacted what is known today as the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act. The Legislature recognized the need for the uniform and systematic provision of emergency medical services to save lives and reduce disability associated with illness and injury.

The emergency medical services (EMS) system of care must be equally capable of assessing, treating, and transporting children, adults, and elderly persons. Today, the Emergency Medical Services Section of the DOH is responsible for the licensure and oversight of over 60,000 emergency medical technicians and paramedics, more than 270 advanced and basic life support agencies, and over 4,500 EMS vehicles. In addition, the section certifies 911 public safety telecommunicators.⁵

Chapter 401, F.S., relates to medical telecommunications and transportation. Part III of ch. 401, F.S., consisting of ss. 401.2101-401.465, F.S., is specific to medical transportation services and provides for the regulation of emergency medical services by the DOH, including:

- The licensure of the emergency medical service entities;
- The certification of the staff employed by those services; and
- The permitting of vehicles used by the staff in those services, whether for basic life support (BLS), advanced life support (ALS), or air ambulance services (AAS).

Every person or entity owning, operating, conducting, maintaining, or engaging in the business of providing prehospital or inter-facility ALS or BLS transportation services must be licensed before offering such service to the public. The DOH issues licenses for the operation of BLS and ALS services for applicants meeting the following requirements:

- Payment of an application fee;

⁵ Department of Health, Licensing and Regulation, *Emergency Medical Services System*, available at: <http://www.floridahealth.gov/licensing-and-regulation/ems-system/index.html> (last visited Oct. 15, 2019).

- Ambulances, equipment, vehicles, personnel, communications systems, staffing patterns, and services of the applicant must meet the requirements for either a BLS service or an ALS service, whichever is applicable;
- Proof of:
 - Personal injury and property damage insurance coverage, in limits set by the DOH, sufficient to cover claims arising out of the injury or death of persons and property damages for which the owner, the business or service would be liable; or
 - Certificate of self-insurance evidencing an adequate self-insurance plan approved by the Office of Insurance Regulation; and
- Certificate of public convenience and necessity from each county in which the applicant will operate.⁶

Each BLS and ALS transportation service must also employ or contract with a medical director to supervise and assume direct responsibility for the medical performance of the emergency medical technicians and paramedics operating for that EMS system. The medical director must be:

- A licensed physician;
- A corporation, association, or partnership composed of physicians; or
- Physicians employed by a hospital that delivers in-hospital EMS and employs or contracts with physicians specifically for that purpose.⁷

The medical director must perform the following duties:

- Advising;
- Consulting;
- Training;
- Counseling; and
- Overseeing of services, including quality assurance.

The medical director's mandated duties do not include administrative and managerial functions. The DOH has rule making authority to regulate medical directors.⁸

The Conrad 30 Program

The Conrad 30 Program, authorized by the U.S. Department of State and the U.S. Citizenship and Immigration Services, addresses the shortage of qualified doctors in medically underserved areas. The program allows a medical doctor holding a J-1 Visa to apply for a waiver of the two-year residence requirement upon completion of the J-1 Visa exchange visitor program under s. 214(1) of the Immigration and Nationality Act.

State public health agencies are authorized to sponsor up to 30 physicians annually to serve in a designated U.S. Department of Health and Human Services (HHS) Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Medically Underserved Populations

⁶ Section 401.25, F.S.

⁷ Section 401.265(1), F.S.

⁸ Id.

(MUP). The program requires a medical doctor holding a J-1 Visa who wishes to participate in a Conrad 30 Program to:

- Agree to be employed full-time in H-1B nonimmigrant status at a health care facility located in an area designated by the U.S. HHS as a HPSA, MUA, or MUP;
- Obtain a contract from the health care facility located in an area designated by U.S. HHS as an HPSA, MUA, or MUP;
- Obtain a “no objection” letter from his or her home country if the home government funded his or her exchange program; and
- Agree to begin employment at the health care facility within 90 days of receipt of the waiver, not the date his or her J-1 visa expires.

The DOH has administered Florida’s Conrad 30 Waiver Program since 1994. In recent years, the number of applicants has exceeded the maximum number of 30 slots allowed by the program. The DOH does not have explicit rulemaking authority to establish additional criteria for selecting the Conrad 30 applicants for sponsorship, thereby limiting the DOH’s ability to place qualified foreign physicians in areas of highest need.⁹

The Department of Health’s General Health Care Professional Licensing Authority
The DOH’s general licensing provisions, authorized under s. 456.013, F.S., require every applicant for licensure to apply to the DOH before sitting for a licensure examination. Section 456.013, F.S., also requires all applications for licensure to be submitted to the DOH on a form that may be submitted electronically. The requirement that an applicant submit his or her application for licensure before sitting for the licensure examination was initially imposed when the DOH developed and administered its own examinations. A strict statutory interpretation of this section requires an applicant, even one who has already passed the licensure examination before applying for a license, to take the examination after applying to the DOH for licensure.

If an applicant has not been issued a social security number at the time of application because the applicant is not a U.S. citizen or resident, the DOH may process the application using a unique personal identification number. If the applicant is otherwise eligible for licensure, the DOH may issue a temporary license, which expires in 30 days after issuance unless a social security number is obtained and submitted in writing to the DOH. Upon receipt of the applicant’s social security number, the DOH must issue a new license, which expires at the end of the current biennium.¹⁰

Section 456.017, F.S., was amended in 2005 to provide that neither a board¹¹ nor the DOH could administer a state-developed written examination if a national examination was certified by the DOH. National examinations have been certified for all professions, and the requirement for applicants to apply to the DOH to take the state examination has become obsolete. All state examinations have ceased.

⁹ Florida Department of Health, *Senate Bill 188 Analysis* (2019) (on file with the Senate Committee on Health Policy), p. 2.

¹⁰ Section 456.01 (1)(b), F.S.

¹¹ 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 DOH or, in some cases, within the DOH Division of Medical Quality Assurance.

The provision also requires an applicant to provide his or her social security number (SSN). However, there is no statutory requirement that an applicant provide his or her date of birth. An applicant's birth date is a requirement to fulfill other statutory licensure requirements under ss. 456.039 and 456.0135, F.S., for fingerprinting and fingerprint retention by the Agency for Health Care Administration (AHCA) and the Care Provider Background Screening Clearinghouse.

According to the DOH, the Joint Administrative Procedures Committee (JAPC) has objected to applications for licensure that contained a data field for the applicant's date of birth. The JAPC indicates that the DOH has no statutory authority to ask for a date of birth. To ensure accurate matches through the Florida Department of Law Enforcement, the Federal Bureau of Investigation, and the Sex Offender Registry, the DOH must have available three identifiers: the name, social security number, and date of birth.¹²

Medical Specialists

A physician licensed under ch. 458, F.S., may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the BOM. A physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the BOM.¹³

Medical Faculty Certificates

To become a licensed medical doctor in Florida, an individual generally has two paths to licensure: licensure by examination¹⁴ or licensure by endorsement.¹⁵ However, s. 458.3145, F.S., provides another limited path to practice in Florida by teaching in a program of medicine. Under s. 458.3145, F.S., the DOH is authorized to issue a medical faculty certificate to a qualified medical physician to practice in conjunction with his or her full-time faculty position at a medical school, if the physician has met specified criteria in current law and accepted a full-time faculty appointment to teach at the following programs in medical schools with campuses in Florida:

- University of Florida;
- University of Miami;
- University of South Florida;
- Florida State University;
- Florida International University;
- University of Central Florida;
- Mayo Clinic College of Medicine and Science in Jacksonville, Florida;
- The Florida Atlantic University; or

¹² *Id.*, at p. 2.

¹³ Section 458.3312, F.S.

¹⁴ See s. 458.311, F.S., and Florida Board of Medicine, *Medical Doctor - Unrestricted*, available at: <http://flboardofmedicine.gov/licensing/medical-doctor-unrestricted> (last visited Oct. 9, 2019).

¹⁵ See s. 458.313, F.S., and Board of Medicine, *Medical Doctor - Unrestricted*, available at: <http://flboardofmedicine.gov/licensing/medical-doctor-unrestricted>, (last visited Oct. 9, 2019).

- The Johns Hopkins All Children's Hospital in St. Petersburg, Florida.¹⁶

The list does not include any medical schools for osteopathic physicians with campuses in Florida.

Currently there are 58 physicians holding medical faculty certificates in Florida, with nine of those residing out of state.¹⁷

Osteopathic Physicians

There are two types of medical physicians fully licensed to practice in Florida. Those holding the M.D. degree – doctor of allopathic medicine – licensed under ch. 458, F.S., and those holding the D.O. degree – doctor of osteopathic medicine – licensed under ch. 459, F.S. Both types of physicians are licensed in Florida to perform surgery and prescribe medicine in hospitals, clinics, and private practices, as well as throughout the U.S. Osteopathic physicians offer all the same services as M.D.s.

Osteopathic physicians can specialize in every recognized area of medicine, from neonatology to neurosurgery, but more than half of all osteopathic physicians practice in primary care areas, such as pediatrics, general practice, obstetrics/gynecology, and internal medicine.¹⁸

Osteopathic Residencies and Florida Licensure

After acquiring a four-year undergraduate college degree with requisite science classes, students are accepted into one of the nation's 21 osteopathic medical schools accredited by the Bureau of Professional Education of the American Osteopathic Association (AOA). Following graduation, osteopathic physicians complete an approved 12-month internship. Interns rotate through hospital departments, including internal medicine, family practice, and surgery. They may then choose to complete a residency program in a specialty area, which requires two to six years of additional training.¹⁹

Any person desiring to be licensed, or certified, as an osteopathic physician in Florida must:

- Submit an application with a fee;
- Be at least 21 years of age;
- Be of good moral character;
- Have completed at least three years of pre-professional postsecondary education;
- Have not previously committed any act that would constitute a violation of ch. 459, F.S.;
- Not be under investigation anywhere for an act that would constitute a violation of ch. 459, F.S.;

¹⁶ Section 458.3145(1)(i), F.S.

¹⁷ Florida Dep't of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan Fiscal Year 2017-2018*, p. 16, available at: <http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/documents/annual-report-1718.pdf> (last visited October 14, 2019).

¹⁸ Florida Osteopathic Medical Association, *Osteopathic Medicine*, available at: <http://www.foma.org/osteopathic-medicine.html> (last visited Oct. 3, 2019).

¹⁹ *Id.*

- Have not been denied a license to practice osteopathic medicine, or had his or her osteopathic medicine license revoked, suspended, or otherwise acted against by any jurisdiction;
- Have met the criteria for:
 - A limited license under s. 459.0075, F.S.;
 - An osteopathic faculty certificate under s. 459.0077, F.S.; or
 - A resident physician, intern, or fellow under s. 459.021, F.S.;
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the AOA;
- Demonstrate that he or she has successfully completed a resident internship of not less than 12 months in a hospital approved by the Board of Trustees of the AOA or any other internship program approved by the Board of Osteopathic Medicine (BOOM) upon a showing of good cause; and
- Demonstrate that he or she has achieved a passing score, established by rule of the BOOM, on all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the BOOM no more than five years before making application.²⁰

The Accreditation Council for Graduate Medical Education (ACGME)

The ACGME is a non-profit corporation whose mission is to improve health care and population health by assessing and advancing the quality of resident physicians' graduate medical education through accreditation.

In the academic year 2018-19, there were approximately 830 ACGME-accredited institutions sponsoring approximately 11,200 residency and fellowship programs in 180 specialties and subspecialties. Accreditation is achieved through a voluntary process of evaluation and review based on published accreditation standards. ACGME accreditation provides assurance that a sponsoring institution or program meets the quality standards (institutional and program requirements) of the specialty or subspecialty practice(s) for which it prepares its graduates. The ACGME accreditation is overseen by a review committee made up of volunteer specialty experts from the field that set accreditation standards and provide peer evaluation of sponsoring institutions and specialty and subspecialty residency and fellowship programs.²¹

The ACGME was established by five medical organizations in 1981²² and, in 2014, was joined by the AOA and the American Association of Colleges of Osteopathic Medicine. A primary responsibility of each of the organizations is to nominate individuals to be considered for membership on the ACGME Board of Directors. The ACGME board currently includes 24 members nominated by member organizations, two resident members, three public directors, four at-large directors, the chair of the Council of Review Committee Chairs, and two non-voting federal representatives.

²⁰ Section 459.0055, F.S.

²¹ American Council of Graduate Medical Education, *What We Do*, available at: <https://www.acgme.org/What-We-Do/Overview> (last visited Oct. 3, 2019).

²² American Council of Graduate Medical Education, *Member Organizations*, , available at: <https://www.acgme.org/About-Us/Overview/Member-Organizations> (last visited Oct. 3, 2019). The five organization are: The American Board of Medical Specialists, The American Hospital Association, The American Medical Association, The Association of American Medical Colleges, and Council of Medical Specialty Societies.

The ACGME sets the standards for graduate medical education (GME) and renders residency accreditation decisions based on compliance with those standards. The member organizations are corporately separate from the ACGME and do not participate in accreditation, pay dues, or make any other monetary contribution to the ACGME. In academic year 2018-19, there were approximately 11,700 ACGME-accredited residency and fellowship programs in 181 specialties and subspecialties at approximately 850 sponsoring institutions. There were approximately 140,500 active full and part time residents and fellows. One out of seven active physicians in the United States is a resident or fellow.²³

As of June 2020, all osteopathic residency programs for GME will need to be ACGME accredited. As the AOA guides residency programs through the process, resident physicians will be protected throughout the transition. If a residency program does not achieve ACGME accreditation by June 2020, a resident who has not completed the required training will be able to complete AOA-accredited training and advance to AOA board eligibility. This is the result of an agreement between the AOA, the ACGME, and the American Association of Colleges of Osteopathic Medicine (AACOM) that gives the AOA restricted authority to extend the AOA accreditation date to allow any remaining resident physicians to finish training in an accredited program. If a resident physician's program does not achieve ACGME accreditation by June 2020, he or she may also be able to transfer to another ACGME accredited program.²⁴

The National Residency Matching Program

The National Resident Matching Program (NRMP) is a private, not-for-profit corporation established in 1952 to optimize the rank-ordered choices of applicants and program directors for residencies and fellowships. The NRMP is not an application processing service. Instead, it provides an impartial venue for matching applicants and program preferences for each other using an internationally recognized mathematical algorithm.

The first Main Residency Match® (“Match”) was conducted in 1952 when 10,400 internship positions were available for 6,000 graduating U.S. medical school seniors. By 1973, there were 19,000 positions for just over 10,000 graduating U.S. seniors. Following the demise of internships in 1975, the number of first-year post-graduate (PGY-1) positions declined to 15,700. The number of PGY-1 positions gradually increased through 1994 and then began to decline slowly until 1998. In 2019, there was an all-time high of 32,194 PGY-1 positions offered. The total number of positions offered, including, PGY-1 and second-year post-graduates (PGY-2), was also at an all-time high of 35,185.²⁵

Beginning in 2014, osteopathic medical school graduates could participate in the Match, which opened up additional residency programs available to osteopathic medical graduates.²⁶ In 2019,

²³ American Council of Graduate Medical Education, *About Us*, available at: <https://www.acgme.org/About-Us/Overview> (last visited Oct. 3, 2019)

²⁴ American Osteopathic Association, *What does single GME mean for DO resident physicians?* available at: <https://osteopathic.org/residents/resident-resources/residents-single-gme/> (last visited Oct. 3, 2019).

²⁵ The Match, National Resident Matching Program, Results and Data 2019 Main Residency Match, *About the NRMP*, p. v, 1, available at: https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf (last visited Oct. 3, 2019).

²⁶ The Accreditation Council for Graduate Medical Education, *Member Organizations*, available at: <https://www.acgme.org/About-Us/Member-Organizations>, (last visited Oct. 3, 2019).

6001 osteopathic candidates applied to the Match and 5077 matched – an 84.6 percent match rate.²⁷ By June 2020, an osteopathic residency program will need to be accredited by ACGME to participate in the Main Residency Match.²⁸

All residents who have completed an AOA- or ACGME-accredited residency program are eligible for AOA board certification. AOA board certification is a quality marker for patients that highlights the commitment to the uniquely osteopathic approach to patient care and allows engagement in continuous professional development throughout a career. Requirements are slightly different for osteopathic medical physicians pursuing certification through the American Board of Medical Specialties (ABMS). The ABMS requires candidates' residency programs to have been ACGME-accredited for a specified amount of time. Requirements vary by specialty.²⁹

Registered Chiropractic Assistants

Registered Chiropractic Assistants (RCAs) perform duties not directly related to chiropractic patient care under the direct supervision of a chiropractic physician or chiropractic physician's assistant. There are no regulatory provisions associated with the work of an RCA. The registration is voluntary and not required for an individual to assist with patient care management activities, execute administrative and clinical procedures, or perform managerial and supervisory functions in an office.³⁰ According to the DOH, in Fiscal Year 2017-2018, there were 2,659 active in-state RCAs.³¹

Florida Center for Nursing

In 2001, the Florida Legislature created s. 464.0195, F.S., establishing the Florida Center for Nursing (FCN) “[t]o address issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse workforce resources.”³² The primary statutory goals address collecting and analyzing nursing workforce data; developing and disseminating a strategic plan for nursing; developing and implementing reward and recognition activities for nurses; and promoting nursing excellence programs, image building, and recruiting into the profession. The FCN is further charged to convene various stakeholder groups to review and comment on nursing workforce data and to recommend systemic changes that will improve the recruitment and retention of nurses in Florida.

The FCN conducts an analysis of licensed practical nurses (LPN), registered nurses (RN), and advanced practice registered nurses (APRN) annually to assess Florida's nurse supply, including the numbers of nurses, demographics, education, employment status, and specialization pursuant

²⁷ *Supra* note 24.

²⁸ The Match, National Residency Match Program, *2020 Match Participation Agreement for Applicants and Programs*, available at: <https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/09/2020-MPA-Main-Residency-Match-for-Applicants-and-Programs.pdf> (last visited Oct. 3, 2019).

²⁹ *Id.*

³⁰ Section 460.4166, F.S.

³¹ The Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2017-2018*, available at: <http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/documents/annual-report-1718.pdf> (last visited Oct. 3, 2019).

³² The Florida Center for Nursing, *2018 Annual Report*, available at: <https://www.flcenterfornursing.org/AboutUs/AnnualReport.aspx> (last visited Oct. 9, 2019).

to s. 467.019, F.S. The FCN submits a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually through January 30, 2020.

Board of Nursing Rulemaking Authority to Establish Standards of Practice

Section 464.004, F.S., established the BON within the DOH to license and regulate nursing to ensure that every nurse practicing in this state meets minimum requirements for safe practice. It was the legislative intent that nurses who fall below minimum competency or who otherwise present a danger to the public should be prohibited from practicing in this state.³³

The Legislature has granted the BON rulemaking authority to:

- Establish guidelines for remedial courses for those nurses who fail the nursing examination three times;³⁴
- Administer the certification of clinical nurse specialists;³⁵
- Administer the certification of advanced practice registered nurses, including the appropriate requirements for advanced practice registered nurses in the categories of certified registered nurse anesthetists, certified nurse midwives, and certified nurse practitioners;³⁶
- Establish a procedure for the biennial renewal of licenses and to prescribe continuing education requirements for renewal of licenses;³⁷
- Provide application procedures for inactive status, the biennial renewal of inactive licenses, and the reactivation of licenses, including applicable fees;³⁸
- Establish the testing procedures for use in certifying nursing assistants, regulating the practice of certified nursing assistants, and specifying the scope of practice and the level of supervision required for the practice of certified nursing assistants;³⁹ and
- Establish disciplinary guidelines.⁴⁰

The Legislature did not expressly grant rulemaking authority to the BON to promulgate nursing standards of practice.⁴¹ The authority to define the scope of practice for nurses is absent from ss. 464.018 and 456.003(6), F.S., which expressly limits the ability of the DOH boards to modify or contravene the lawful scope of practice of a regulated profession.

From 2003 through 2012, the BON proposed various rules on nursing standards of practice for conscious sedation and unprofessional conduct, which were ultimately withdrawn after the JAPC objected.

³³ Section 456.002, F.S.

³⁴ Section 464.008, F.S.

³⁵ Section 464.0115, F.S.

³⁶ Section 464.012, F.S.

³⁷ Section 464.013, F.S.

³⁸ Section 464.014, F.S.

³⁹ Section 464.202, F.S.

⁴⁰ Section 464.018(5), F.S.

⁴¹ See *Florida Medical Association, Inc., Florida Osteopathic Medical Association, and Florida Podiatric Medical Association vs. Department Of Health, Board Of Nursing*, DOAH Case No. 12-001545 RP, *Summary Final Order*, Nov. 2, 2012; *affirmed per curiam*, *Department of Health, Board of Nursing, Florida Association of Nurse Anesthetists and Florida Nurses Association, v. Florida Medical Association, Inc., Florida Osteopathic Medical Association, Inc., and Florida Podiatric Medical Association*, Case Nos. 1D12-5656, 1D12-5671, 1D12-5739 (Fla. 1st DCA, Feb. 12, 2014).

In 2012, the BON proposed another rule establishing professional guidelines for the administration of conscious sedation and to update the instances of unprofessional conduct. The 2012 rule was met with rule challenges from various associations, and the JAPC objected to the rule as lacking statutory rulemaking authority. The rule was ultimately challenged at the Division of Administrative Hearings (DOAH) in case number 121545RP. That decision found that the BON lacked the statutory authority to define nursing “scope of practice” in the Nurse Practice Act. The decision was affirmed by the First District Court of Appeal in case numbers 1D12-5656, 1D12-5671, and 1D12-5739 (all related to DOAH 12-1545RP).

The Legislature has granted statutory authority to set standards of practice for professions that are authorized to practice independently, including: allopathic and osteopathic physicians,⁴² podiatric physicians,⁴³ pharmacists,⁴⁴ psychotherapists,⁴⁵ clinical social workers,⁴⁶ dentists,⁴⁷ optometrists,⁴⁸ and opticians.⁴⁹

Certified Nursing Assistants (CNAs)

Section 464.201(5), F.S., defines the practice of a CNA as providing care and assisting persons with tasks relating to the activities of daily living. Activities of daily living include tasks associated with: personal care, maintaining mobility, nutrition and hydration, toileting and elimination, assistive devices, safety and cleanliness, data gathering, reporting abnormal signs and symptoms, postmortem care, patient socialization and reality orientation, end-of-life care, cardiopulmonary resuscitation and emergency care, patients’ rights, documentation of nursing-assistant services, and other tasks that a CNA may perform after training.⁵⁰

The BON issues certificates to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write, successfully passes the required background screening, and demonstrates:

- Successful completion of an approved training program and achieving no less than a minimum score;
- Achieving a minimum score on the nursing assistant competency examination, and:
 - Having a high school diploma, or its equivalent; or,
 - Being at least 18 years of age;
- Being currently certified in another state and having not been found to have committed abuse, neglect, or exploitation in that state; and
- Having completed the curriculum developed under the Enterprise Florida Jobs and Education Partnership Grant and achieving a minimum score.⁵¹

⁴² Sections 458.331(1)(v) and 459.015(1)(z), F.S.

⁴³ Section 461.003, F.S.

⁴⁴ Sections 465.003(13) and 465.0155, F.S.

⁴⁵ Section 490.003(4), F.S.

⁴⁶ Section 491.003, F.S.

⁴⁷ Section 466.003(3), F.S.

⁴⁸ Section 463.005(1)(a), F.S.

⁴⁹ Section 463.002(7), F.S.

⁵⁰ Section 464.201, F.S.

⁵¹ Section 464.203, F.S.

Section 464.204, F.S., relating to the denial, suspension, or revocation of a CNA certification, sets forth the grounds for the BON to discipline a CNA. Two actions constitute grounds for which the BON may impose disciplinary sanctions:

- Obtaining or attempting to obtain certification or an exemption, or possessing or attempting to possess certification or a letter of exemption, by bribery, misrepresentation, deceit, or through an error of the BON; and
- Intentionally violating any provision of ch. 464, F.S., ch. 456, F.S., or the rules adopted by the BON.

When pursuing discipline against a CNA, the DOH must be prepared to prove that the CNA “intentionally” violated the law or rule.

The BON can only approve applications for licensure by endorsement from currently licensed CNAs in other states. If a CNA from the District of Columbia or a U.S. territory wishes to be licensed in Florida, he or she must apply for licensure by examination instead of endorsement.⁵²

Dentistry, Dental Hygiene, Health Access Dental Licensure, and Dental Laboratories

Licensure Examinations for Dentists and Dental Hygienists

Section 466.004, F.S., establishes the Board of Dentistry (BOD) within the DOH to regulate the practice of dentistry and dental hygiene. The requirements for dental licensure by examination are found in s. 466.006, F.S. A person desiring to be licensed as a dentist must apply to the DOH to take the examinations. To take the examination, an applicant must be 18 years of age and be:

- A graduate from a dental school accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) or any other dental accrediting entity recognized by the U.S. Department of Education (DOE); or
- A dental student in the final year of a program at such an ADA CODA accredited dental school who has completed all the coursework necessary to prepare the student to perform the clinical and diagnostic procedures required to pass the examinations.

Dental school graduates from a school not accredited by the ADA CODA, the U.S. DOE recognized dental accrediting entity, or approved by the BOD, desiring to take the Florida dental licensure examinations, are not entitled to take the examinations until the applicant:

- Demonstrates completion of a program of study defined by BOD rule, at an accredited American dental school and receipt of a D.D.S. or D.M.D. from the school; or
- Submits proof of successful completion of at least two consecutive years at a full-time supplemental general dentistry program accredited by the ADA CODA.⁵³

The Legislature has authorized the BOD to use the American Dental Licensing Examination (ADLEX), developed by the American Board of Dental Examiners, Inc., in lieu of an independent state-developed practical or clinical examination. Section 466.007, F.S., requires a dental hygiene applicant to pass the American Dental Hygiene Licensing Examination (ADHEX) also developed by the American Board of Dental Examiners, Inc.

⁵² *Id.*

⁵³ *Supra* note 9, p. 3. According to the DOH, it is unclear whether the two years of a full time supplemental general dentistry program includes specialty or advanced education programs.

Sections 466.006(4)(b) and 466.007(4)(b), F.S., require that the ADLEX examination for dentists, and ADHEX for hygienists, be graded by Florida licensed dentists, and dentists and hygienists, respectively. Such practitioners must be employed by the DOH for this purpose. This provision refers to requirements that were necessary when the ADLEX and ADHEX examinations were purchased and administered by the DOH. This requirement is now obsolete since the BOD has certified national examinations for both dentists and hygienists.

According to the DOH, by limiting the grading to Florida-only licensed dentists and hygienists, this requirement has created a shortage of personnel available to grade the examinations, thus jeopardizing the administration of the ADLEX and the ADHEX.⁵⁴

Health Access Dental Licensure

In 2008, the Legislature established the health access dental license in order to attract out-of-state dentists to practice in underserved health access settings.⁵⁵ With this license, a dentist actively licensed in good standing in another state, the District of Columbia, or a U.S. territory is authorized to practice dentistry in Florida in a health access setting if the dentist:

- Submits proof he or she graduated from a dental school accredited by the Commission on Dental Accreditation of the ADA or its successor agency;
- Submits proof he or she has successfully completed parts I and II of the National Board of Dental Examiners (NBDE) examination and a state or regional clinical dental licensing examination that the BOD has determined effectively measures the applicant's ability to practice safely;
- Submits ADLEX examination scores mailed to the BOD directly from the American Dental Association;
- Submits a final official transcript from a dental school sent to the BOD by the registrar's office;
- Submits a certification of licensure from each state in which he or she currently holds or has held a dental or dental hygiene license;
- Submits proof of training in cardiopulmonary resuscitation (CPR) at the basic support level;
- Files a BOD-approved application and pays the applicable fees;
- Has not been convicted of, nor pled *nolo contendere* to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Currently holds a valid, active dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another state, the District of Columbia, or a U.S. territory;
- Has never had a license revoked from another state, the District of Columbia, or a U.S. territory;

⁵⁴ *Supra* note 9, p. 4.

⁵⁵ A "health access setting" is defined in s. 466.003(14), F.S., as a program or institution of the Department of Children and Families, the Department of Health, or the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center (FQHC) or FQHC look-alike as defined by federal law, a school-based prevention program, or a clinic operated by an accredited college of dentistry or an accredited dental hygiene program in this state if such community service programs and institutions immediately report to the Board of Dentistry practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such settings.

- Has never failed an exam under s. 466.006, F.S., unless the applicant was reexamined and received a license to practice in Florida;
- Has not been reported to the NBDE, unless the applicant successfully appealed to have his or her name removed from the data bank;
- Submits proof that he or she has been engaged in the active, clinical practice of dentistry and has provided direct patient care for five years immediately preceding the date of application, or proof of continuous clinical practice, and has provided direct patient care since graduation if the applicant graduated less than five years from his or her application date;⁵⁶
- Submits documentation that she or he has completed, or will complete prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006, F.S., for the last full reporting biennium before applying for a health access dental license;⁵⁷ and
- Successfully completes the examination covering the laws and rules of the practice of dentistry in this state.^{58,59}

A health access dental license is subject to biennial renewal. The BOD will renew a health access dental license if the applicant:

- Submits a renewal application and has paid a renewal fee;
- Submits documentation from the employer in the health access setting that the licensee has at all times pertinent remained an employee;
- Has not been convicted of, nor pled *nolo contendere* to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Has not failed the examination specified in s. 466.006, F.S., since initially receiving a health access dental license or since the last renewal; and
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank.

The BOD may undertake measures to independently verify the health access dental licensee's ongoing employment status in the health access setting.⁶⁰

The BOD may revoke a health access dental license if the licensee is terminated from employment at the health access setting or practices outside of the health access setting, fails the Florida dental examination, or is found by the BOD to have committed a violation of ch. 466, F.S., (the Dental Practice Act), other than a violation that is a citation offense or a minor violation.⁶¹

⁵⁶ Section 466.0067, F.S.

⁵⁷ See ch. 64B5-12.013, Fla. Admin. Code Rule (2019), for continuing education requirements.

⁵⁸ Section 466.006(4)(a), F.S.

⁵⁹ Department of Health, Board of Dentistry, *Health Access Dentist*, available at: <https://floridasdentistry.gov/licensing/health-access-dentist/> (last visited Oct. 3, 2019).

⁶⁰ Section 466.00671, F.S.

⁶¹ Section 466.00672, F.S.

Currently, there are 58 health access dental licenses. Of those, 37 are in-state active, two are in-state delinquent, 10 are out-of-state active, two are out-of-state delinquent, and seven are retired.⁶²

The program is scheduled for repeal effective January 1, 2020, unless reenacted by the Legislature.⁶³

Adverse Incident Reporting in the Practice of Dentistry

There is no statutory requirement for dentists or dental hygienists to report adverse incidents or occurrences in office practice settings. In contrast, the BOM and BOOM have specific statutory authority to require licensees to report adverse incidents in office practice settings.⁶⁴

The BOD, by rule, defines an “adverse occurrence” and specifies reporting requirements. The rule specifies that an adverse occurrence in a dental office must be reported to the BOD within 48 hours followed by a more specific written report within 30 days. These reports are forwarded to the chair of the Probable Cause Panel to determine if further investigation is necessary. If further investigation is warranted, the report and recommendation are forwarded to the MQA Consumer Services Unit (CSU) for further investigation. All reported mortalities occurring in a dental office are forwarded to the CSU for investigation.

The rule does not provide a penalty for failure to report an adverse occurrence.⁶⁵

Dental Laboratories

Section 466.031, F.S., defines a “dental laboratory” to include any person, firm, or corporation who, for a fee or gratuitously, manufactures artificial substitutes for natural teeth, or who furnishes, supplies, constructs, reproduces, or repairs any prosthetic denture, bridge, or appliance to be worn in the human mouth, or which holds itself out as a dental laboratory. The definition specifically excludes a dental laboratory technician who constructs or repairs dental prosthetic appliances in the office of a licensed dentist, for that dentist only, and under the dentist’s supervision and work order.

Section 466.032, F.S., sets forth the registration and biennial registration renewal for a dental laboratory. It directs the DOH to issue a certificate upon payment of a fee, which entitles the registrant to operate a dental laboratory for a period of two years. Section 466.032, F.S., sets forth the requirements for a periodic inspection of dental laboratories for required equipment and supplies, mandates 18 hours biennially of continuing education for the dental laboratory owner

⁶² Florida Dept. of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan FY 2017-2018*, 14, available at: <http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/index.html> (last visited Oct. 3, 2019). “In-State Active” means the licensed practitioner has a Florida mailing address and is authorized to practice. “In-State Delinquent” means the licensed practitioner has a Florida mailing address and is not authorized to practice in the state because of failure to renew the license by the expiration date. “Out-of-State Active” means the licensed practitioner has an out-of-state mailing address and is authorized to practice. “Out-of-State Inactive” means the licensed practitioner has an out-of-state mailing address and is not authorized to practice. “Retired” means the licensed practitioner is not authorized to practice. The practitioner is not obligated to update licensure data. Section 456.036, F.S.

⁶³ Section 466.00673, F.S.

⁶⁴ Sections 458.351 and 459.026, F.S.

⁶⁵ Fla. Admin. Code. R. 64B5-14.006 (2019).

or at least one employee who must be in programs of learning that contribute directly to the education of the dental technician, and establishes disciplinary guidelines for violations.

According to the DOH, there were 989 dental laboratories in Florida as of June 30, 2018; 792 have active licenses and 197 have delinquent licenses.⁶⁶ In the 2017-18 fiscal year, the DOH reports that there were four cases opened against dental laboratories, none of which resulted in disciplinary cases.⁶⁷

Athletic Trainers

Section 468.073, F.S., establishes the Board of Athletic Trainers (BOAT) within the DOH to license and regulate the practice of athletic trainers in Florida. Applicants for licensure as an athletic trainer are required to:

- Submit to a background screening;
- Have a baccalaureate or higher degree from a college or university in professional athletic training accredited by the Commission on Accreditation of Athletic Training Education, and have passed the national examination to be certified by the Board of Certification (BOC)⁶⁸ for athletic trainers;
- Have a current certification from the BOC, if they graduated before 2004;⁶⁹ and
- Have current certifications in cardiopulmonary resuscitation (CPR) and the use of an automated external defibrillator (AED).⁷⁰

An athletic trainer must practice under the direction of an allopathic, osteopathic or chiropractic physician licensed under chs. 458, 459, or 460, F.S., or otherwise authorized by Florida law. The physician must communicate his or her direction through oral or written prescriptions or protocols for the provision of services and care by the athletic trainer, and the athletic trainer must provide service or care as dictated by the physician.⁷¹

The services an athletic trainer is authorized to provide relate to the prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury, illness, or other condition involving exercise, sport, recreation, or related physical activity. In providing care and services, an athletic trainer may use physical

⁶⁶ *Supra* note 62, p. 19.

⁶⁷ *Supra* note 62, p. 34.

⁶⁸ The Board of Certification, Inc. (BOC) was incorporated in 1989 as a not-for-profit credentialing agency to provide a certification program for the entry level athletic training profession. The BOC establishes both the standards for the practice of athletic training and the continuing education requirements for BOC Certified Athletic Trainers (ATs). The BOC also works with state regulatory agencies to provide credential information, professional conduct guidelines and regulatory standards on certification issues. The BOC also has the only accredited certification program for ATs in the United States and has mutual recognition agreements with Canada and Ireland. *See* Board of Certification for the Athletic Trainer, *What is BOC?* available at <http://www.bocatc.org/about-us#what-is-the-boc> (last visited Oct. 3, 2019).

⁶⁹ *Supra* note 9, p. 4. According to the DOH, prior to 2004, and the inception of athletic training programs, athletic trainers obtained training through a Board of Certification (BOC) internship program to obtain licensure in Florida. Current law does not allow athletic trainers who obtained training through the BOC internship program to become licensed in Florida.

⁷⁰ Section 468.707, F.S.

⁷¹ Section 468.713, F.S.

modalities, including, but not limited to, heat, light, sound, cold, electricity, and mechanical devices.⁷²

The BOAT is authorized to adopt rules to implement the provisions of part XIII, ch. 468, F.S. Such rules must include, but are not limited to:

- The allowable scope of practice regarding the use of equipment, procedures, and medication;
- Mandatory requirements and guidelines for communication between the athletic trainer and a physician, including the reporting to the physician of new or recurring injuries or conditions;
- Licensure requirements;
- Licensure examination;
- Continuing education requirements;
- Fees;
- Records and reports to be filed by licensees;
- Protocols; and,
- Any other requirements necessary to regulate the practice of athletic training.⁷³

At renewal, licensed athletic trainers must demonstrate a current BOC certification; however, there is no requirement for that certification to be held without lapse and in good standing.⁷⁴

Orthotics, Prosthetics, and Pedorthics

Section 468.801, F.S., establishes the Board of Orthotists and Prosthetists (BOOP) within the DOH to license and regulate the practice of Prosthetist-Orthotist, Prosthetist,⁷⁵ Orthotist,⁷⁶ Pedorthist,⁷⁷ Orthotic Fitter, and Orthotic Fitter Assistant in Florida. Applicants for licensure under part XIV, ch. 468, F.S., must:

- Submit an application and fee, not to exceed \$500;
- Submit fingerprints for background screening;
- Submit the cost of the state and national criminal background checks;
- Be of good moral character;
- Be 18 years of age or older; and
- Have completed the appropriate educational preparation requirements.⁷⁸

Licenses must be granted independently in orthotics, prosthetics, or pedorthics, but a person may be licensed in more than one discipline. A prosthetist-orthotist license may be granted to persons

⁷² Section 468.701, F.S.

⁷³ Section 468.705, F.S.

⁷⁴ Section 468.711, F.S.

⁷⁵ Section 468.80(15), F.S., defines “prosthetics” as the practice of evaluating, treatment formulating, measuring, designing, fabricating, assembling, fitting, adjusting, servicing, or providing the initial training necessary to accomplish the fitting of a prosthesis.

⁷⁶ Section 468.80(9), F.S., defines “orthotics” as the practice of evaluating, treatment formulating, measuring, designing, fabricating, assembling, fitting, adjusting, servicing, or providing the initial training necessary to accomplish the fitting of an orthosis or pedorthic device.

⁷⁷ Section 468.80(12), F.S., defines “pedorthics” as the practice of evaluating, treatment formulating, measuring, designing, fabricating, assembling, fitting, adjusting, servicing, or providing the initial training necessary to accomplish the fitting of a pedorthic device.

⁷⁸ Section 468.803, F.S.

meeting the requirements for both a prosthetist and an orthotist license. Persons seeking to obtain the required orthotics or prosthetics experience in the state must be approved by the BOOP and registered as a resident by the DOH. A registration may be held in both practice fields, but the board may not approve a second registration until at least one year after the issuance of the first registration.⁷⁹ Currently, a dual registration is not authorized.⁸⁰

Massage Therapy

Section 480.035, F.S., establishes the Board of Massage Therapy (BMT) within the DOH to license and regulate the practice of massage in Florida. Individuals seeking an initial massage therapist license in Florida have two options for meeting the educational requirements:

- They may attend an approved program at a massage therapy school and complete 500 hours of classroom training; or
- They can become an apprentice under a licensed massage therapist for a period of one year. During that year, the sponsor of the massage apprentice is required to file quarterly reports and the apprentice must complete the following courses of study: 300 hours of physiology, 300 hours of anatomy, 20 hours of theory and history of massage, 50 hours of theory and practice of hydro-therapy, five hours of hygiene, 25 hours of statutes and rules of massage practice, 50 hours of introduction to allied modalities, 700 hours of practical massage, and three hours of board-approved HIV/AIDS instruction.⁸¹

Any person may obtain a license to practice as a massage therapist if he or she:

- Submits an application and fee;
- Is at least 18 years of age;
- Has received a high school diploma or high school equivalency diploma;
- Submits to background screening;
- Has completed a course of study at a board-approved massage school or has completed an apprenticeship program that meets standards adopted by the board; and,
- Has received a passing grade on an examination testing general areas of competency specified by the board⁸² and administered by the DOH.⁸³

Rule 64B7-25.001(2), F.A.C., lists five national exams that are approved by the board. The exam currently taken by applicants is the National Examination for State Licensure administered by the National Certification Board for Therapeutic Massage and Bodywork. The DOH does not offer or administer a specific state licensure exam.⁸⁴ According to the DOH, there are 172 approved licensed massage schools in Florida, and 32,387 licensed massage therapists in the 2017-2018 fiscal year. There were only 71 apprentices licensed under the Florida apprenticeship program.⁸⁵

⁷⁹ *Id.*

⁸⁰ *Supra* note 9, p.4.

⁸¹ Fla. Admin. Code R. 64B7-29.003, (2019).

⁸² Section 480.042, F.S.

⁸³ Section 480.041, F.S.

⁸⁴ *Id.*

⁸⁵ *Supra* note 62, p.15.

The term “massage” is defined as the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not the manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation.⁸⁶

The BMT also licenses apprentices in colonic hydrotherapy.⁸⁷ These individuals are either attending a massage therapy school that does not offer colonic training or are licensed massage therapists who are seeking to add colonic hydrotherapy to their practice. Since there are few schools in the state that offer a colonic hydrotherapy program, apprenticeships are the primary method of training for this service.⁸⁸

Psychology

Section 490.004, F.S., creates the Board of Psychology (BOP) within the DOH to license and regulate the practice of psychologists in Florida. The practice of psychology is defined as the observation, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and enhancing interpersonal behavioral health and mental or psychological health.⁸⁹

Licensure as a psychologist under ch. 490, F.S., requires a doctoral degree in psychology from an educational institution that, at the time the applicant was enrolled and graduated, held institutional accreditation from an approved agency and programmatic accreditation from the American Psychological Association (APA).

Section 490.003(3)(a), F.S., refers to educational requirements in effect prior to July 1, 1999, and are no longer applicable. The outdated language could create confusion among applicants as to the current educational requirements, which are correctly defined in s. 490.003(3)(b), F.S. Section 490.003(3)(b), F.S., generically refers to programs approved and recognized by the U.S. DOE. The only accrediting agency recognized by the U.S. DOE to provide programmatic accreditation for doctoral psychology programs is the APA.

Section 490.005, F.S., refers to educational requirements in effect prior to July 1, 1999, which are no longer applicable to augment a deficient education or show comparability to the current educational requirements. This section includes an outdated reference to the APA accrediting programs in Canada. Currently, the APA no longer accredits Canadian doctoral programs.⁹⁰

Section 490.005(2)(b)1., F.S., refers to school psychology applicants graduating from a college or university accredited and approved by the Commission on Recognition of Postsecondary Accreditation; however, the correct reference is to the Council for Higher Education Accreditation.

⁸⁶ Section 480.033, F.S.

⁸⁷ Colonic hydrotherapy is a method of colon irrigation used to cleanse the colon with the aid of a mechanical device and water. *See* s. 480.033(6), F.S.

⁸⁸ Fla. Admin. Code R. 64B7-29.007, (2019).

⁸⁹ Section 490.003(4), F.S.

⁹⁰ *Supra* note 9, p.10.

Section 490.006, F.S., relating to licensure of a psychologist or school psychologist by endorsement, requires:

- Submission of an application to the DOH and payment of a fee;
- Proof of a valid license or certificate in another jurisdiction provided that, when the applicant secured such license or certificate, the requirements were substantially equivalent to or more stringent than those set forth in ch. 490, F.S. (but, if no Florida law existed at that time the applicant received his or her license or certificate, then the requirements in the other state must have been substantially equivalent to or more stringent than those set forth in ch. 490, F.S., when the application is made);
- Proof of good standing as a diplomat with the American Board of Psychology; or
- Proof of a doctoral degree in psychology as described in s. 490.003, F.S., and at least 20 years of experience as a licensed psychologist in any jurisdiction or territory of the United States within the 25 years preceding the date of application.

Obtaining licensure under the current endorsement standards requires a law-to-law comparison, and applicants who otherwise might qualify for licensure may be denied, or have licensure delayed, until they select a different application method.

Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

Section 491.004, F.S., creates the Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling within the DOH to ensure that every clinical social worker, marriage and family therapist, and mental health counselor practicing in this state meets minimum requirements for safe practice. The Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling is responsible for licensing, monitoring, disciplining, and educating clinical social workers, marriage and family therapists, and mental health counselors to assure competency and safety to practice in Florida.

Section 491.005, F.S., sets out the educational and examination requirements for a clinical social worker, marriage and family therapist, and mental health counselor to obtain a license by examination in Florida. An individual applying for licensure by examination who has satisfied the clinical experience requirements of s. 491.005, F.S., or an individual applying for licensure by endorsement pursuant to s. 491.006, F.S., intending to provide clinical social work, marriage and family therapy, or mental health counseling services in Florida, while satisfying coursework or examination requirements for licensure, must obtain a provisional license in the profession for which he or she is seeking licensure prior to beginning practice.⁹¹

An individual who has not satisfied the postgraduate or post-master's level of experience requirements under s. 491.005, F.S., must register as an intern in the profession for which he or she is seeking licensure before commencing the post-master's experience requirement. An individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience, outside the academic arena for any profession, must register as an intern in the

⁹¹ Section 491.0046, F.S.

profession for which he or she is seeking licensure before commencing the practicum, internship, or field experience.⁹²

Section 491.0045(6), F.S., specifies the length of time an intern registration for clinical social work, marriage and family therapy, and mental health counseling is valid. A footnote to this section points out that, through multiple amendatory acts to s. 491.0045(6), F.S., during the same legislative session, two irreconcilable versions of the section were created, and the editors were thus required to publish both versions of the amended provision.

Section 491.0045(6), F.S., states, “[a]n intern registration issued on or before March 31, 2017, expires March 31, 2022, and may not be renewed or reissued. A registration issued after March 31, 2017, expires 60 months after the date of issuance. No subsequent intern registration may be issued unless the candidate has passed the theory and practice examination described in s. 491.005(1)(d), (3)(d), and (4)(d).” The footnote refers to an April 1, 2017, date, rather than the March 31, 2017 in the statute.

Section 491.005(3)(b), F.S., relating to licensure by examination for marriage and family therapists requires:

- A master’s degree with major emphasis in marriage and family therapy or a closely related field;
- Specific coursework in 12 content areas; and
- A practicum, internship, or field experience of 180 hours providing direct client contact hours of marriage and family services under the supervision of a licensed marriage and family therapist with at least five years of experience.

Section 491.005(3)(c), F.S., is inconsistent as it requires both two years, and three years, of clinical experience for a marriage and family therapy licensure applicant. According to the DOH, the three years of clinical experience was a technical error and is inconsistent with other statutory requirements. Only two years of clinical experience for a marriage and family therapy applicant is required.⁹³

Section 491.005(4), F.S., relating to licensure by examination for mental health counselors names the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors as the required examination for a mental health counselor. The correct name of the examination required for licensure as a mental health counselor is the National Clinical Mental Health Counseling Examination. The examination was developed by, and is administered by, the National Board for Certified Counselors.

Section 491.005(4), F.S., contains a 300-hour difference between the hours of practicum, internship, or field experience required for graduates from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) and non-CACREP graduates. A mental health counselor applicant who graduated from a program not accredited by CACREP is required to complete 1,000 hours of practicum, internship, or field experience. An MHC

⁹² Section 491.0045, F.S.

⁹³ *Id.*

applicant who graduated from a CACREP accredited program is required to meet the CACREP standards to complete 700 hours of practicum or internship.⁹⁴

Section 491.006, F.S., relating to licensure or certification by endorsement requires an applicant for licensure by endorsement in the practice of clinical social work, marriage and family therapy, or mental health counseling to demonstrate to the board that he or she:

- Has knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling;
- Holds an active valid license to practice, and has actively practiced the profession in another state, for three of the last five years immediately preceding licensure;
- Meets the education requirements of ch. 491, F.S., in the profession for which the applicant seeks licensure;
- Has passed a substantially equivalent licensure examination in another state, or has passed the licensure examination in this state in the profession for which the applicant seeks licensure;
- Holds a license in good standing; and
- Is not under investigation for, nor has been found to have committed, an act that would constitute a violation of ch. 491, F.S.

To satisfy the education requirements of s. 491.005, F.S., specific particular course work, rather than a degree from an accredited school or college, or proof of licensure in another state, is required of an applicant for licensure by endorsement under ch. 491, F.S. The endorsement applicant must show proof that he or she completed certain statutorily-specified courses, which may not have been available at the time he or she graduated. Current law places barriers on licensure by endorsement by requiring many applicants to complete additional courses often difficult to obtain when the applicant is not a full-time graduate student.

Section 491.007(3), F.S., provides for the renewal of a license, registration, or certificate for clinical social workers, marriage and family therapists, and mental health counselors, and gives the Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling rulemaking authority to prescribe the requirements for renewal of an intern registration. Section 491.0045(6), F.S., now addresses renewal of an intern registration; therefore, rulemaking authority is no longer necessary.

Section 491.009, F.S., sets out what acts by a clinical social worker, marriage and family therapist, or mental health counselor constitute grounds for discipline, or denial of licensure. However, s. 491.009(2), F.S., incorrectly references psychologists, who are not licensed under ch. 491, F.S., and does not include the certified master social worker profession regulated by the DOH.

III. Effect of Proposed Changes:

Section 1: Human Immunodeficiency Virus (HIV)

⁹⁴ Council for Accreditation of Counseling & Related Educational Programs, *2016 CACREP Standards*, available at: <http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf> (last visited Oct. 3, 2019).

The bill amends s. 381.0042, F.S., the statute for patient care for persons with AIDS, to replace the term “acquired immune deficiency syndrome” with “human immunodeficiency virus” to broaden the purpose of the DOH’s regional patient care networks to include persons with HIV, who might not have developed AIDS, as well as patients with AIDS.

Section 2: The Conrad 30 Waiver Program

The bill amends s. 381.4018(3), F.S., to authorize the DOH to adopt rules to implement that subsection, which includes the implementation of the federal Conrad 30 Waiver Program to encourage qualified physicians to relocate to Florida and practice in medically underserved and rural areas.

Section 3: Emergency Medical Transport Services

The bill amends s. 401.35, F.S., and modifies the DOH’s directive to develop rules for emergency medical transportation services, and:

- Requires the DOH rules to provide minimal standards governing ambulance and EMS vehicle equipment and supplies that a licensee with a valid vehicle permit under s. 402.26 F.S., is required to maintain for providing basic life support and advanced life support;
- Deletes the requirement that the DOH rules on ambulance and EMS equipment and supplies be at least as comprehensive as standards published in the most current edition of the American College of Surgeons’ Committee on Trauma;
- Deletes the requirement that the standards for the DOH rules on ambulance and EMS vehicle design and construction be at least equal to those most currently recommended by the U.S. General Services Administration; and
- Requires the DOH rules on ambulance and EMS vehicle design and construction to be based on national standards, as interpreted by the DOH, on the date the rule is adopted.

Section 4: The DOH General Health Care Professional Licensing Provisions

The bill amends s. 456.013, F.S., to eliminate obsolete language regarding applying to the DOH to take an examination. The bill adds the date of birth as a required element on the application, which provides an increased likelihood of a confirmation of a criminal background check for the DOH.

The bill also permits the DOH to issue a temporary license to a non-resident or non-citizen, eligible applicant, who has accepted a position with a residency, internship, or fellowship program in Florida and is applying for registration under ss. 458.345 or 459.021, F.S. The temporary license expires in 60 days, instead of 30, unless the applicant is issued a social security number and submits it in writing to the DOH.

Section 5: Medical Faculty Certificates

The bill amends s. 458.3145, F.S., to authorize the DOH to issue medical faculty certificates, without examination, to qualified foreign physicians, and qualified physicians licensed in another jurisdiction, who have been offered, and accepted, full-time faculty positions in a program of

medicine at Nova Southeastern University or Lake Erie College of Osteopathic Medicine, in addition to those programs of medicine already listed in current law.

Section 6: Medical Specialists

The bill amends s. 458.3312, F.S., relating to holding oneself out as a medical specialist, to repeal the requirement that the BOM conduct a review of organizations that board-certify physicians in dermatology every three years in order for a physician to hold himself or herself out as board-certified in dermatology.

Section 7: Osteopathic Internships and Residencies

The bill amends s. 459.0055, F.S., to recognize the agreement between the AOA and the ACGME. Both organizations have committed to improving the patient care delivered by resident and fellow physicians today and in their future independent practice, and to do so in clinical learning environments characterized by excellence in care, safety, and professionalism, thereby creating a single path for GME. This single path for GME allows osteopathic and allopathic medical school graduates to seek residencies and fellowship programs accreditation by ACGME. This will enable osteopathic medical school graduates, residents, and fellows to apply to the National Resident Match Program and participate in the Main Residency Match for internships, residencies, and fellowships, thereby creating more residency opportunities for osteopathic residents.

Section 8: Registered Chiropractic Assistants (RCAs)

The bill repeals s. 460.4166, F.S., thus deregulating the profession of RCAs, as the duties an RCA performs are not directly related to patient safety and the registration is voluntary.

Sections 9 through 12: The Florida Center for Nursing (FCN), Board of Nursing (BON) Rulemaking Authority, and Certified Nursing Assistants

The bill amends s. 464.019, F.S., to extend the requirement for the FCN to provide an implementation study and annual report on the availability of nursing programs and production of quality nurses to the Governor, the President of the Senate, and the Speaker of the House of Representatives until January 30, 2025, as opposed to January 30, 2020, under current law.

The bill amends ss. 464.202, 464.203, and 464.204, F.S., relating to rulemaking, duties, and powers of the BON, to authorize the BON to create rules detailing standards of practice for its licensees, which include: APRNs, clinical nurse specialists, RNs, LPNs, and CNAs.

The bill authorizes the BON to grant licenses by endorsement, for CNA applicants with certifications in U.S. territories or Washington, D.C. This will expedite licensure as a CNA because the applicant would no longer have to apply for licensure by examination.

The bill amends s. 464.204, F.S., to eliminate the element of intent to violate the laws or rules relating to CNAs, which will align CNA prosecution with the law for disciplining registered nurses and licensed practical nurses.

Sections 13 and 17: Examinations for Dental and Hygiene Graduates

The bill amends ss. 406.006(3), F.S., to clarify that a “supplemental general dentistry program” does not include an advanced education program in a dental specialty and amends ss. 406.006(4) and 466.007, F.S., to delete the requirement that the ADLEX and ADHEX given in Florida must be graded by a Florida licensed dentist, or dentist and hygienist, respectively.

The bill amends ss. 466.006 and 466.007, F.S., to eliminate obsolete dental and dental hygiene licensure examination requirements.

Sections 14, 15, and 16: Health Access Dental Licensure

The bill revives, reenacts, and amends ss. 466.0067, 466.00671, and 466.00672, F.S., notwithstanding the January 1, 2020, repeal date for those sections. The bill’s amendments to those sections are for the purpose of grammatical corrections only.

Section 18: Dental Adverse Incident Reporting

The bill amends s. 466.017, F.S., to require dentists and dental hygienists to report adverse incidents to the DOH, which is currently only required by a BOD rule. This new section requires the reporting of deaths, or any incident that results in the temporary or permanent physical or mental injury, that requires hospitalization or emergency room treatment of a dental patient that occurred during or as a result of the use of anesthesia or sedation, and creates grounds for discipline for the failure to report an adverse incident.

Sections 19 and 20: Dental Laboratories

The bill amends s. 466.031, F.S., to authorize an employee or independent contractor of a dental laboratory, acting as an agent of that dental laboratory, to engage in onsite consultation with a licensed dentist during a dental procedure.

The bill amends s. 466.036, F.S., to require that a dental laboratory must be inspected at least biennially.

Sections 21 through 25: Athletic Trainers

The bill amends s. 468.701, F.S., to remove a substantive statutory provision from the definition of “athletic trainer” and relocate that provision to s. 468.713, F.S. The provision in question restricts a licensed athletic trainer from providing, offering to provide, or representing that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing. The bill also specifies within s. 468.713, F.S. that an athletic trainer must work within his or her allowable scope of practice as specified in BOAT rule under s. 468.705, F.S.

The bill amends the licensure requirements for an athletic trainer to create a new licensure pathway for applicants who hold a bachelor’s degree, have completed the BOC internship program, and hold a current certification from the BOC to become licensed in Florida.

The bill amends s. 468.711, F.S., relating to licensure renewal requirements to require an athletic trainer to maintain his or her BOC certification in good standing without lapse. Licensees will have to demonstrate continuous good standing of his or her BOC certification at the time of renewal.

The bill gives the BOAT rulemaking authority to further define the supervision between an athletic training student and a licensed athletic trainer rather than relying on compliance with standards set by an external entity.

Section 26: Orthotics, Prosthetics, and Pedorthics

The bill amends s. 468.803, F.S., to authorize the DOH to issue a joint registration in orthotics and prosthetics as a dual registration rather than requiring separate registrations and to recognize the dual residency program and educational requirements for dual registration.

Sections 27, 28, and 29: Massage Therapy

The bill amends the definition of “apprentice” in s. 480.033(5), F.S., to eliminate the statutory authority for massage therapy apprenticeships, except for apprentices studying colonic hydrotherapy. The bill allows apprentices licensed before July 1, 2020, to maintain their apprentice license until its expiration date, but no later than July 1, 2023, and to qualify for licensure based on that apprenticeship.

The bill amends s. 480.041, F.S., to specify that the licensure examination is a national examination designated by the BMT, not an examination administered by the BMT.

The bill repeals s. 480.042, F.S., relating to a massage therapy examination by the board, which is obsolete.

Sections 30, 31, and 32: Psychology

The bill amends s. 490.003, F.S., to eliminate outdated language in s. 490.003(3)(a), F.S.

The bill amends and renumbers s. 490.003(3)(b), F.S., to delete the generic reference to programs accredited by an agency recognized and approved by the U.S. DOE, and inserts a specific reference to the American Psychological Association (APA), which is the only accrediting agency recognized by the U.S. DOE to provide program accreditation for doctoral psychology programs. A specific reference to the APA clarifies current education requirements, but does not impose any new requirements.

The bill amends s. 490.005, F.S., relating to licensure by examination for psychologists. The bill eliminates the specific reference to Canada, which will allow applicants who obtained their education anywhere outside the U.S. to demonstrate they have an education comparable to an APA accredited program.

The bill removes outdated language referencing an augmented or comparable doctoral education pathway. The ability of applicants who obtained their degree in the United States, to augment an insufficient degree or show comparability to an APA accredited program, is no longer available.

The bill eliminates an outdated reference to the school psychology educational accrediting agency, the Commission on Recognition of Postsecondary Accreditation, and updates the reference with the successor agency, the Council for Higher Education Accreditation.

The bill amends s. 490.006, F.S., relating to a psychologist licensure by endorsement, to eliminate the requirement that the licensing provisions of the other state must have been substantially equivalent to, or more stringent than, those of either the law in Florida at the time the applicant obtained an out-of-state license or the current Florida law. The bill reduces from 20 years of licensed psychology experience, to 10 years of experience, within the preceding 25 years from the date of application. Licensure of qualified applicants will be expedited by amending these provisions.

Sections 33 through 38: Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

The bill amends s. 491.0045, F.S., to clarify conflicting language passed in the same legislative session to permit the Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling to make a one-time exception for an additional intern registration for interns registered on or before March 31, 2017. For those interns who's registration expires March 31, 2022, the board may grant an additional intern registration in emergency or hardship cases, as defined by board rule, if the candidate has passed the theory and practice examination described in ss. 491.055(1)(d), (3)(d), and (4)(d), F.S.

The bill amends s. 491.005(3), F.S., relating to licensure by examination for marriage and family therapists, to require:

- A master's degree with major emphasis in marriage and family therapy from a program accredited by the Commission of Accreditation for Marriage and Family Therapy Education; or,
- A master's degree with major emphasis in marriage and family therapy from a Florida university program accredited by the Council for Accreditation of Counseling and Related Education Programs and graduate courses approved by the board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling.

The bill eliminates the requirement for marriage and family therapists to complete 12 specific content areas and 180 practicum hours. This change will simplify the education review process, eliminate the course requirement review, and expedite licensure.

The bill amends s. 491.005(3)(c), F.S., to correct a technical discrepancy in the number of years of clinical experience required for a marriage and family therapist applicant from three years to two years.

The bill amends s. 491.005(4), F.S., relating to mental health counseling applicants to update the name of the examination to be taken by mental health counselor applicants. The bill amends

s. 491.005(4)(b)1.c., F.S., to reduce the number of practicum, internship, or field experience hours for those applicants who graduated from a non-CACREP accredited program, from 1,000 hours to 700 hours, to bring this provision in line with graduates from CACREP accredited programs.

The bill amends s. 491.006, F.S., relating to licensure, or certification by endorsement, for applicants for licensure in clinical social work, marriage and family therapy, or mental health counseling. The bill removes the requirement for endorsement applicants to meet the same educational requirements required of new applicants, provided the applicant for endorsement meets the requirements to have an active, valid license and has actively practiced the profession in another state for three of the last five years. Amending this provision will increase licensure portability for applicants applying by endorsement for licensure as marriage and family therapists in Florida.

The bill amends s. 491.007, F.S., relating to renewal of a license, registration, or certificate, to delete obsolete board rulemaking authority regarding intern registration renewal.

The bill amends s. 491.009(2), F.S., to delete an inaccurate reference to psychologists who are licensed under ch. 490, F.S., and to add the profession of certified master social worker that is licensed under ch. 491, F.S. The bill corrects a reference to the DOH, and places the correct reference of authority with the board to take disciplinary action for certain violations. By adding certified master social worker to this provision, the bill gives the DOH authority to enter an order denying licensure to a certified master social worker or impose discipline against any certified master social worker who is found guilty of violating any provision in ch. 491, F.S.

Sections 39: Technical Changes

The bill makes additional technical amendments to ss. 491.0046 and 945.42, F.S., to conform cross-references and makes a technical change to s. 945.42, F.S., to conform the definition of psychological professional in cross-references.

Section 40 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 230 has an insignificant negative impact on state revenues and expenditures. The deregulation of chiropractic assistants will result in an insignificant negative impact on state revenues associated with the licensure of chiropractic assistants, which will be offset by the reduction in expenditures associated with regulating chiropractic assistants. The DOH will experience an insignificant increase in workload associated with rulemaking activities required in the bill. These costs can be absorbed within existing resources of the DOH.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0042, 381.4018, 401.35, 456.013, 458.3145, 458.3312, 459.0055, 464.019, 464.202, 464.203, 464.204, 466.006, 466.0067, 466.00671, 466.00672, 466.007, 466.017, 466.031, 466.036, 468.701, 468.707, 468.711, 468.713, 468.723, 468.803, 480.033, 480.041, 490.003, 490.005, 490.006, 491.0045, 491.005, 491.006, 491.007, 491.009, 491.0046, and 945.42.

This bill repeals the following sections of the Florida Statutes: 406.4166 and 480.042.

IX. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

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

CS by Health Policy on October 15, 2019:

The CS:

- Replaces the term “acquired immune deficiency syndrome” with “human immunodeficiency virus” to broaden the purpose of the DOH’s regional patient care networks to include persons with HIV, who might not have developed AIDS, as well as patients with AIDS;
- Modifies the DOH’s rule-making authority pertaining to minimal standards governing ambulance and emergency medical services vehicle equipment, supplies, design, and construction;
- Revises the DOH’s health care practitioner licensing provisions to permit the DOH to issue a temporary license, that expires in 60 days, instead of 30 days, to a non-resident or non-citizen physician who has accepted a residency, internship, or fellowship in Florida and has not yet received a social security number; and
- Authorizes the DOH to issue medical faculty certificates, without examination, to full-time faculty at Nova Southeastern University or Lake Erie College of Osteopathic Medicine.

B. Amendments:

None.



878466

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
10/15/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Between lines 109 and 110
insert:

Section 1. Section 381.0042, Florida Statutes, is amended
to read:

381.0042 Patient care for persons with HIV infection.—The
department may establish human immunodeficiency virus ~~acquired~~
~~immune deficiency syndrome~~ patient care networks in each region
of the state where the number ~~numbers~~ of cases of ~~acquired~~



878466

~~immune deficiency syndrome and other~~ human immunodeficiency virus transmission infections justifies the establishment of cost-effective regional patient care networks. Such networks shall be delineated by rule of the department which shall take into account natural trade areas and centers of medical excellence that specialize in the treatment of human immunodeficiency virus ~~acquired immune deficiency syndrome~~, as well as available federal, state, and other funds. Each patient care network shall include representation of persons with human immunodeficiency virus infection; health care providers; business interests; the department, including, but not limited to, county health departments; and local units of government. Each network shall plan for the care and treatment of persons who have with acquired the human immunodeficiency virus ~~immune deficiency syndrome and acquired immune deficiency syndrome~~ ~~related complex~~ in a cost-effective, dignified manner that ~~which~~ emphasizes outpatient and home care. Once per each year, ~~beginning April 1989~~, each network shall make its recommendations concerning the needs for patient care to the department.

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

And the title is amended as follows:

Between lines 2 and 3
insert:

s. 381.0042, F.S.; revising the purpose of patient care networks from serving patients with acquired immune deficiency syndrome to those who have acquired the human immunodeficiency virus; conforming



878466

40 provisions to changes made by the act; deleting
41 obsolete language; amending
42



641130

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
10/15/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Between lines 222 and 223
insert:

Section 2. Paragraphs (c) and (d) of subsection (1) of
section 401.35, Florida Statutes, are amended to read:

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

(1) The rules must provide at least minimum standards



641130

governing:

(c) ~~Ground Ambulance and~~ emergency medical services vehicle equipment and supplies that a licensee's medical director is required to maintain to provide basic or advanced life support services ~~at least as comprehensive as those published in the most current edition of the American College of Surgeons, Committee on Trauma, list of essential equipment for ambulances, as interpreted by rules of the department.~~

(d) ~~Ground Ambulance or~~ emergency medical services vehicle design and construction based on national standards in effect on the date the rule is adopted and ~~at least equal to those most currently recommended by the United States General Services Administration as interpreted by~~ department rule ~~rules of the department.~~

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

And the title is amended as follows:

Between lines 7 and 8
insert:

401.35, F.S.; expanding applicability of certain ambulance rules to emergency medical services vehicles; specifying that a licensee's medical director is responsible for maintaining certain vehicle equipment and supplies; deleting the requirement that the department base such rules on certain association or agency standards and instead requiring the department to base such rules on national standards in effect on a certain date; amending s.



284886

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
10/15/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Substitute for Amendment (641130) (with title amendment)

Between lines 222 and 223
insert:

Section 2. Paragraphs (c) and (d) of subsection (1) of section 401.35, Florida Statutes, are amended to read:

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



284886

(1) The rules must provide at least minimum standards governing:

(c) ~~Ground~~ Ambulance and emergency medical services vehicle equipment and supplies that a licensee with a valid vehicle permit under s. 401.26 is required to maintain to provide basic life support or advanced life support services ~~at least as comprehensive as those published in the most current edition of the American College of Surgeons, Committee on Trauma, list of essential equipment for ambulances, as interpreted by rules of the department.~~

(d) ~~Ground~~ Ambulance or emergency medical services vehicle design and construction based on national standards in effect on the date the rule is adopted and ~~at least equal to those most currently recommended by the United States General Services Administration as interpreted by~~ department rule ~~rules of the department.~~

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

And the title is amended as follows:

Between lines 7 and 8
insert:

401.35, F.S.; clarifying applicability of certain ambulance rules to include emergency medical services vehicles; deleting the requirement that the department base rules governing medical supplies and equipment required in ambulances and emergency medical services vehicles on a certain association's standards; deleting the requirement that the department base rules governing ambulance or emergency medical



284886

40 services vehicle design and construction on a certain
41 agency's standards and instead requiring the
42 department to base such rules on national standards in
43 effect on a certain date; amending s.



367440

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
10/15/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Between lines 252 and 253
insert:

Section 3. Subsection (1) of section 458.3145, Florida
Statutes, is amended to read

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without
examination to an individual who:

(a) Is a graduate of an accredited medical school or its



367440

equivalent, or is a graduate of a foreign medical school listed with the World Health Organization;

(b) Holds a valid, current license to practice medicine in another jurisdiction;

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed \$500;

(d) Has completed an approved residency or fellowship of at least 1 year or has received training which has been determined by the board to be equivalent to the 1-year residency requirement;

(e) Is at least 21 years of age;

(f) Is of good moral character;

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331;

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry; and

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at:

1. The University of Florida;
2. The University of Miami;
3. The University of South Florida;
4. The Florida State University;
5. The Florida International University;
6. The University of Central Florida;



367440

7. The Mayo Clinic College of Medicine and Science in
Jacksonville, Florida;

8. The Florida Atlantic University; ~~or~~

9. The Johns Hopkins All Children's Hospital in St.
Petersburg, Florida;

10. Nova Southeastern University; or

11. Lake Erie College of Osteopathic Medicine.

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

And the title is amended as follows:

Between lines 9 and 10

insert:

458.3145, F.S.; revising the list of individuals who
may be issued a medical faculty certificate without
examination; amending s.



952710

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
10/15/2019	.	
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	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 252 and 253
insert:

(b) If an applicant has not been issued a social security number by the Federal Government at the time of application because the applicant is not a citizen or resident of this country, the department may process the application using a unique personal identification number. If such an applicant is otherwise eligible for licensure, the board, or the department



952710

when there is no board, may issue a temporary license to the applicant, which shall expire 30 days after issuance unless a social security number is obtained and submitted in writing to the department. A temporary license issued under this paragraph to an applicant who has accepted a position with an accredited residency, internship, or fellowship program in this state and is applying for registration under s. 458.345 or s. 459.021 shall expire 60 days after issuance unless the applicant obtains a social security number and submits it in writing to the department. Upon receipt of the applicant's social security number, the department shall issue a new license, which shall expire at the end of the current biennium.

===== 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 223 - 224

and insert:

Section 2. Paragraphs (a) and (b) of subsection (1) of section 456.013, Florida Statutes, are amended to read:

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

And the title is amended as follows:

Delete line 9

and insert:

licensure application requirements; authorizing the board or department to issue a temporary license to certain applicants which expires after 60 days; amending s.

By Senator Harrell

25-00375A-20

2020230__

1 A bill to be entitled
 2 An act relating to the Department of Health; amending
 3 s. 381.4018, F.S.; requiring the department to develop
 4 strategies to maximize federal-state partnerships that
 5 provide incentives for physicians to practice in
 6 medically underserved or rural areas; authorizing the
 7 department to adopt certain rules; amending s.
 8 456.013, F.S.; revising health care practitioner
 9 licensure application requirements; amending s.
 10 458.3312, F.S.; removing a prohibition against
 11 physicians representing themselves as board-certified
 12 specialists in dermatology unless the recognizing
 13 agency is reviewed and reauthorized on a specified
 14 basis by the Board of Medicine; amending s. 459.0055,
 15 F.S.; revising licensure requirements for a person
 16 seeking licensure or certification as an osteopathic
 17 physician; repealing s. 460.4166, F.S., relating to
 18 registered chiropractic assistants; amending s.
 19 464.019, F.S.; extending through 2025 the Florida
 20 Center for Nursing's responsibility to study and issue
 21 an annual report on the implementation of nursing
 22 education programs; amending s. 464.202, F.S.;
 23 requiring the Board of Nursing to adopt rules that
 24 include disciplinary procedures and standards of
 25 practice for certified nursing assistants; amending s.
 26 464.203, F.S.; revising certification requirements for
 27 nursing assistants; amending s. 464.204, F.S.;
 28 revising grounds for board-imposed disciplinary
 29 sanctions; amending s. 466.006, F.S.; revising certain

Page 1 of 54

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

25-00375A-20

2020230__

30 examination requirements for applicants seeking dental
 31 licensure; reviving, reenacting, and amending s.
 32 466.0067, F.S., relating to the application for a
 33 health access dental license; reviving, reenacting,
 34 and amending s. 466.00671, F.S., relating to the
 35 renewal of such a license; reviving and reenacting s.
 36 466.00672, F.S., relating to the revocation of such a
 37 license; amending s. 466.007, F.S.; revising
 38 requirements for examinations of dental hygienists;
 39 amending s. 466.017, F.S.; requiring dentists and
 40 certified registered dental hygienists to report in
 41 writing certain adverse incidents to the department
 42 within a specified timeframe; providing for
 43 disciplinary action by the Board of Dentistry for
 44 violations; defining the term "adverse incident";
 45 authorizing the board to adopt rules; amending s.
 46 466.031, F.S.; making technical changes; authorizing
 47 an employee or an independent contractor of a dental
 48 laboratory, acting as an agent of that dental
 49 laboratory, to engage in onsite consultation with a
 50 licensed dentist during a dental procedure; amending
 51 s. 466.036, F.S.; revising the frequency of dental
 52 laboratory inspections during a specified period;
 53 amending s. 468.701, F.S.; revising the definition of
 54 the term "athletic trainer"; deleting a requirement
 55 that is relocated to another section; amending s.
 56 468.707, F.S.; revising athletic trainer licensure
 57 requirements; amending s. 468.711, F.S.; requiring
 58 certain licensees to maintain certification in good

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

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2020230__

59 standing without lapse as a condition of renewal of
 60 their athletic trainer licenses; amending s. 468.713,
 61 F.S.; requiring that an athletic trainer work within a
 62 specified scope of practice; relocating an existing
 63 requirement that was stricken from another section;
 64 amending s. 468.723, F.S.; requiring the direct
 65 supervision of an athletic training student to be in
 66 accordance with rules adopted by the Board of Athletic
 67 Training; amending s. 468.803, F.S.; revising
 68 orthotic, prosthetic, and pedorthic licensure,
 69 registration, and examination requirements; amending
 70 s. 480.033, F.S.; revising the definition of the term
 71 "apprentice"; amending s. 480.041, F.S.; revising
 72 qualifications for licensure as a massage therapist;
 73 specifying that massage apprentices licensed before a
 74 specified date may continue to perform massage therapy
 75 as authorized under their licenses; authorizing
 76 massage apprentices to apply for full licensure upon
 77 completion of their apprenticeships, under certain
 78 conditions; repealing s. 480.042, F.S., relating to
 79 examinations for licensure as a massage therapist;
 80 amending s. 490.003, F.S.; revising the definition of
 81 the terms "doctoral-level psychological education" and
 82 "doctoral degree in psychology"; amending s. 490.005,
 83 F.S.; revising requirements for licensure by
 84 examination of psychologists and school psychologists;
 85 amending s. 490.006, F.S.; revising requirements for
 86 licensure by endorsement of psychologists and school
 87 psychologists; amending s. 491.0045, F.S.; exempting

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

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88 clinical social worker interns, marriage and family
 89 therapist interns, and mental health counselor interns
 90 from registration requirements, under certain
 91 circumstances; amending s. 491.005, F.S.; revising
 92 requirements for the licensure by examination of
 93 marriage and family therapists; revising requirements
 94 for the licensure by examination of mental health
 95 counselors; amending s. 491.006, F.S.; revising
 96 requirements for licensure by endorsement or
 97 certification for specified professions; amending s.
 98 491.007, F.S.; removing a biennial intern registration
 99 fee; amending s. 491.009, F.S.; authorizing the Board
 100 of Clinical Social Work, Marriage and Family Therapy,
 101 and Mental Health Counseling or, under certain
 102 circumstances, the department to enter an order
 103 denying licensure or imposing penalties against an
 104 applicant for licensure under certain circumstances;
 105 amending ss. 491.0046 and 945.42, F.S.; conforming
 106 cross-references; providing an effective date.

107
 108 Be It Enacted by the Legislature of the State of Florida:

109
 110 Section 1. Subsection (3) of section 381.4018, Florida
 111 Statutes, is amended to read:

112 381.4018 Physician workforce assessment and development.—
 113 (3) GENERAL FUNCTIONS.—The department shall maximize the
 114 use of existing programs under the jurisdiction of the
 115 department and other state agencies and coordinate governmental
 116 and nongovernmental stakeholders and resources in order to

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

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develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the department shall:

(a) Monitor, evaluate, and report on the supply and distribution of physicians licensed under chapter 458 or chapter 459. The department shall maintain a database to serve as a statewide source of data concerning the physician workforce.

(b) Develop a model and quantify, on an ongoing basis, the adequacy of the state's current and future physician workforce as reliable data becomes available. Such model must take into account demographics, physician practice status, place of education and training, generational changes, population growth, economic indicators, and issues concerning the "pipeline" into medical education.

(c) Develop and recommend strategies to determine whether the number of qualified medical school applicants who might become competent, practicing physicians in this state will be sufficient to meet the capacity of the state's medical schools. If appropriate, the department shall, working with representatives of appropriate governmental and nongovernmental entities, develop strategies and recommendations and identify best practice programs that introduce health care as a profession and strengthen skills needed for medical school admission for elementary, middle, and high school students, and improve premedical education at the precollege and college level in order to increase this state's potential pool of medical students.

(d) Develop strategies to ensure that the number of graduates from the state's public and private allopathic and

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osteopathic medical schools is adequate to meet physician workforce needs, based on the analysis of the physician workforce data, so as to provide a high-quality medical education to students in a manner that recognizes the uniqueness of each new and existing medical school in this state.

(e) Pursue strategies and policies to create, expand, and maintain graduate medical education positions in the state based on the analysis of the physician workforce data. Such strategies and policies must take into account the effect of federal funding limitations on the expansion and creation of positions in graduate medical education. The department shall develop options to address such federal funding limitations. The department shall consider options to provide direct state funding for graduate medical education positions in a manner that addresses requirements and needs relative to accreditation of graduate medical education programs. The department shall consider funding residency positions as a means of addressing needed physician specialty areas, rural areas having a shortage of physicians, and areas of ongoing critical need, and as a means of addressing the state's physician workforce needs based on an ongoing analysis of physician workforce data.

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas, in otherwise medically underserved areas, or in rural areas. Strategies shall also consider the use of state programs, such as the Medical

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Education Reimbursement and Loan Repayment Program pursuant to s. 1009.65, which provide for education loan repayment or loan forgiveness and provide monetary incentives for physicians to relocate to underserved areas of the state.

(g) Coordinate and enhance activities relative to physician workforce needs, undergraduate medical education, graduate medical education, and reentry of retired military and other physicians into the physician workforce provided by the Division of Medical Quality Assurance, area health education center networks established pursuant to s. 381.0402, and other offices and programs within the department as designated by the State Surgeon General.

(h) Work in conjunction with and act as a coordinating body for governmental and nongovernmental stakeholders to address matters relating to the state's physician workforce assessment and development for the purpose of ensuring an adequate supply of well-trained physicians to meet the state's future needs. Such governmental stakeholders shall include, but need not be limited to, the State Surgeon General or his or her designee, the Commissioner of Education or his or her designee, the Secretary of Health Care Administration or his or her designee, and the Chancellor of the State University System or his or her designee, and, at the discretion of the department, other representatives of state and local agencies that are involved in assessing, educating, or training the state's current or future physicians. Other stakeholders shall include, but need not be limited to, organizations representing the state's public and private allopathic and osteopathic medical schools; organizations representing hospitals and other institutions

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providing health care, particularly those that currently provide or have an interest in providing accredited medical education and graduate medical education to medical students and medical residents; organizations representing allopathic and osteopathic practicing physicians; and, at the discretion of the department, representatives of other organizations or entities involved in assessing, educating, or training the state's current or future physicians.

(i) Serve as a liaison with other states and federal agencies and programs in order to enhance resources available to the state's physician workforce and medical education continuum.

(j) Act as a clearinghouse for collecting and disseminating information concerning the physician workforce and medical education continuum in this state.

The department may adopt rules to implement this subsection, including rules that establish guidelines to implement the federal Conrad 30 Waiver Program created under s. 214(1) of the Immigration and Nationality Act.

Section 2. Paragraph (a) of subsection (1) of section 456.013, Florida Statutes, is amended to read:

456.013 Department; general licensing provisions.—

(1) (a) Any person desiring to be licensed in a profession within the jurisdiction of the department ~~must shall~~ apply to the department in writing ~~to take the licensure examination~~. The application must ~~shall~~ be made on a form prepared and furnished by the department. The application form must be available on the Internet, World Wide Web and the department may accept electronically submitted applications. The application shall

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require the social security number and date of birth of the applicant, except as provided in paragraphs (b) and (c). The form shall be supplemented as needed to reflect any material change in any circumstance or condition stated in the application which takes place between the initial filing of the application and the final grant or denial of the license and which might affect the decision of the department. If an application is submitted electronically, the department may require supplemental materials, including an original signature of the applicant and verification of credentials, to be submitted in a nonelectronic format. An incomplete application shall expire 1 year after initial filing. In order to further the economic development goals of the state, and notwithstanding any law to the contrary, the department may enter into an agreement with the county tax collector for the purpose of appointing the county tax collector as the department's agent to accept applications for licenses and applications for renewals of licenses. The agreement must specify the time within which the tax collector must forward any applications and accompanying application fees to the department.

Section 3. Section 458.3312, Florida Statutes, is amended to read:

458.3312 Specialties.—A physician licensed under this chapter may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the board. However, a physician may indicate the services offered and may state that his or her practice is

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limited to one or more types of services when this accurately reflects the scope of practice of the physician. ~~A physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the Board of Medicine.~~

Section 4. Subsection (1) of section 459.0055, Florida Statutes, is amended to read:

459.0055 General licensure requirements.—

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

(a) Complete an application form and submit the appropriate fee to the department;

(b) Be at least 21 years of age;

(c) Be of good moral character;

(d) Have completed at least 3 years of preprofessional postsecondary education;

(e) Have not previously committed any act that would constitute a violation of this chapter, unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;

(f) Not be under investigation in any jurisdiction for an act that would constitute a violation of this chapter. If, upon completion of such investigation, it is determined that the applicant has committed an act that would constitute a violation of this chapter, the applicant is ineligible for licensure unless the board determines that such act does not adversely

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291 affect the applicant's present ability and fitness to practice
 292 osteopathic medicine;

293 (g) Have not had an application for a license to practice
 294 osteopathic medicine denied or a license to practice osteopathic
 295 medicine revoked, suspended, or otherwise acted against by the
 296 licensing authority of any jurisdiction unless the board
 297 determines that the grounds on which such action was taken do
 298 not adversely affect the applicant's present ability and fitness
 299 to practice osteopathic medicine. A licensing authority's
 300 acceptance of a physician's relinquishment of license,
 301 stipulation, consent order, or other settlement, offered in
 302 response to or in anticipation of the filing of administrative
 303 charges against the osteopathic physician, shall be considered
 304 action against the osteopathic physician's license;

305 (h) Not have received less than a satisfactory evaluation
 306 from an internship, residency, or fellowship training program,
 307 unless the board determines that such act does not adversely
 308 affect the applicant's present ability and fitness to practice
 309 osteopathic medicine. Such evaluation shall be provided by the
 310 director of medical education from the medical training
 311 facility;

312 (i) Have met the criteria set forth in s. 459.0075, s.
 313 459.0077, or s. 459.021, whichever is applicable;

314 (j) Submit to the department a set of fingerprints on a
 315 form and under procedures specified by the department, along
 316 with a payment in an amount equal to the costs incurred by the
 317 Department of Health for the criminal background check of the
 318 applicant;

319 (k) Demonstrate that he or she is a graduate of a medical

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320 college recognized and approved by the American Osteopathic
 321 Association;

322 (l) Demonstrate that she or he has successfully completed
 323 an internship or residency ~~a resident internship~~ of not less
 324 than 12 months in a program accredited ~~hospital approved~~ for
 325 this purpose by ~~the Board of Trustees of the American~~
 326 Osteopathic Association or the Accreditation Council for
 327 Graduate Medical Education ~~any other internship program approved~~
 328 ~~by the board upon a showing of good cause by the applicant.~~ This
 329 requirement may be waived for an applicant who matriculated in a
 330 college of osteopathic medicine during or before 1948; and

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

342 Section 5. Section 460.4166, Florida Statutes, is repealed.

343 Section 6. Subsection (10) of section 464.019, Florida
 344 Statutes, is amended to read:

345 464.019 Approval of nursing education programs.—

346 (10) IMPLEMENTATION STUDY.—The Florida Center for Nursing
 347 shall study the administration of this section and submit
 348 reports to the Governor, the President of the Senate, and the

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Speaker of the House of Representatives annually by January 30, through January 30, 2025 ~~2020~~. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing.

(a) The Florida Center for Nursing shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

1. The number of programs and student slots available.

2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

3. The number of program graduates.

4. Program retention rates of students tracked from program entry to graduation.

5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.

6. The number of graduates who become employed as practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board's implementation of the:

1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1), ~~+~~ the number of program applications approved and denied by the board under subsection (2), ~~+~~ the number of denials

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of program applications reviewed under chapter 120, ~~+~~ and a description of the outcomes of those reviews.

2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the reports required by this subsection.

Section 7. Section 464.202, Florida Statutes, is amended to read:

464.202 Duties and powers of the board.—The board shall maintain, or contract with or approve another entity to maintain, a state registry of certified nursing assistants. The registry must consist of the name of each certified nursing assistant in this state; other identifying information defined by board rule; certification status; the effective date of certification; other information required by state or federal law; information regarding any crime or any abuse, neglect, or exploitation as provided under chapter 435; and any disciplinary action taken against the certified nursing assistant. The registry shall be accessible to the public, the certificateholder, employers, and other state agencies. The

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board shall adopt by rule testing procedures for use in certifying nursing assistants and shall adopt rules regulating the practice of certified nursing assistants, including disciplinary procedures and standards of practice, and specifying the scope of practice authorized and the level of supervision required for the practice of certified nursing assistants. The board may contract with or approve another entity or organization to provide the examination services, including the development and administration of examinations. The board shall require that the contract provider offer certified nursing assistant applications via the Internet, and may require the contract provider to accept certified nursing assistant applications for processing via the Internet. The board shall require the contract provider to provide the preliminary results of the certified nursing examination on the date the test is administered. The provider shall pay all reasonable costs and expenses incurred by the board in evaluating the provider's application and performance during the delivery of services, including examination services and procedures for maintaining the certified nursing assistant registry.

Section 8. Paragraph (c) of subsection (1) of section 464.203, Florida Statutes, is amended to read:

464.203 Certified nursing assistants; certification requirement.—

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the

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person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days before applying for a certificate to practice and the person's background screening results are not retained in the clearinghouse created under s. 435.12, the board shall waive the requirement that the applicant successfully pass an additional background screening pursuant to s. 400.215. The person must also meet one of the following requirements:

(c) Is currently certified in another state or territory of the United States or in the District of Columbia; is listed on that jurisdiction's ~~state's~~ certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that jurisdiction ~~state~~.

Section 9. Paragraph (b) of subsection (1) of section 464.204, Florida Statutes, is amended to read:

464.204 Denial, suspension, or revocation of certification; disciplinary actions.—

(1) The following acts constitute grounds for which the board may impose disciplinary sanctions as specified in subsection (2):

(b) ~~Intentionally~~ Violating any provision of this chapter, chapter 456, or the rules adopted by the board.

Section 10. Subsections (3) and (4) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(3) If an applicant is a graduate of a dental college or school not accredited in accordance with paragraph (2)(b) or of a dental college or school not approved by the board, the applicant is not entitled to take the examinations required in

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this section to practice dentistry until she or he satisfies one of the following:

(a) Completes a program of study, as defined by the board by rule, at an accredited American dental school and demonstrates receipt of a D.D.S. or D.M.D. from said school; or

(b) Submits proof of having successfully completed at least 2 consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this paragraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty.

(4) Notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations, to be licensed as a dentist in this state, an applicant must successfully complete both of the following:

(a) A written examination on the laws and rules of the state regulating the practice of dentistry.

(b) ~~1-~~ A practical or clinical examination, which must ~~shall~~ be the American Dental Licensing Examination produced by the American Board of Dental Examiners, Inc., or its successor entity, if any, that is administered in this state ~~and graded by dentists licensed in this state and employed by the department for just such purpose~~, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the

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examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally. A passing score on the American Dental Licensing Examination administered in this state ~~and graded by dentists who are licensed in this state~~ is valid for 365 days after the date the official examination results are published.

1.2-a. As an alternative to such practical or clinical examination ~~the requirements of subparagraph 1-~~, an applicant may submit scores from an American Dental Licensing Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results shall be recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination administered out of state ~~out-of-state~~ shall be the same as the passing score for the American Dental Licensing Examination administered in this state ~~and graded by dentists who are licensed in this state~~. The examination results are valid for 365 days after the date the official examination results are published. The applicant must have completed the examination after October 1, 2011.

~~b-~~ This subparagraph may not be given retroactive application.

2.3- If the date of an applicant's passing American Dental Licensing Examination scores from an examination previously administered in a jurisdiction other than this state under subparagraph 1. ~~subparagraph 2-~~ is older than 365 days, ~~then~~ such scores are ~~shall~~ nevertheless ~~be recognized as~~ valid for

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the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

a. ~~(I)~~ The applicant completed the American Dental Licensing Examination after October 1, 2011.

~~(II)~~ This sub-subparagraph may not be given retroactive application;

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this paragraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty;

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico;

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d. The applicant submits proof that he or she has never been reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name removed from the data banks of these agencies;

e. (I) ~~(A) In the 5 years immediately preceding the date of application for licensure in this state,~~ The applicant submits ~~must submit~~ proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico in the 5 years immediately preceding the date of application for licensure in this state; ~~or,~~

(B) If the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant submits ~~must submit~~ proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

(II) As used in this section, "full-time practice" is defined as a minimum of 1,200 hours per year for each and every year in the consecutive 5-year period or, ~~when where~~ applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or

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581 accredited by the American Dental Association Commission on
582 Dental Accreditation.

583 (C) Full-time practice as a student at a postgraduate
584 dental education program approved by the board or accredited by
585 the American Dental Association Commission on Dental
586 Accreditation.

587 (III) The board shall develop rules to determine what type
588 of proof of full-time practice is required and to recoup the
589 cost to the board of verifying full-time practice under this
590 section. Such proof must, at a minimum, be:

591 (A) Admissible as evidence in an administrative proceeding;

592 (B) Submitted in writing;

593 (C) Submitted by the applicant under oath with penalties of
594 perjury attached;

595 (D) Further documented by an affidavit of someone unrelated
596 to the applicant who is familiar with the applicant's practice
597 and testifies with particularity that the applicant has been
598 engaged in full-time practice; and

599 (E) Specifically found by the board to be both credible and
600 admissible.

601 (IV) An affidavit of only the applicant is not acceptable
602 proof of full-time practice unless it is further attested to by
603 someone unrelated to the applicant who has personal knowledge of
604 the applicant's practice. If the board deems it necessary to
605 assess credibility or accuracy, the board may require the
606 applicant or the applicant's witnesses to appear before the
607 board and give oral testimony under oath;

608 f. The applicant submits ~~must submit~~ documentation that he
609 or she has completed, or will complete before he or she is

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610 ~~licensed, prior to licensure~~ in this state, continuing education
611 equivalent to this state's requirements for the last full
612 reporting biennium;

613 g. The applicant ~~proves must prove~~ that he or she has never
614 been convicted of, or pled nolo contendere to, regardless of
615 adjudication, any felony or misdemeanor related to the practice
616 of a health care profession in any jurisdiction;

617 h. The applicant has ~~must~~ successfully passed ~~pass~~ a
618 written examination on the laws and rules of this state
619 regulating the practice of dentistry and ~~must successfully pass~~
620 the computer-based diagnostic skills examination; and

621 i. The applicant submits ~~must submit~~ documentation that he
622 or she has successfully completed the applicable examination
623 administered by the Joint Commission on National Dental
624 Examinations or its successor organization ~~National Board of~~
625 ~~Dental Examiners dental examination.~~

626 Section 11. Notwithstanding the January 1, 2020, repeal of
627 section 466.0067, Florida Statutes, that section is revived,
628 reenacted, and amended, to read:

629 466.0067 Application for health access dental license.—The
630 Legislature finds that there is an important state interest in
631 attracting dentists to practice in underserved health access
632 settings in this state and further, that allowing out-of-state
633 dentists who meet certain criteria to practice in health access
634 settings without the supervision of a dentist licensed in this
635 state is substantially related to achieving this important state
636 interest. Therefore, notwithstanding the requirements of s.
637 466.006, the board shall grant a health access dental license to
638 practice dentistry in this state in health access settings as

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defined in s. 466.003 to an applicant who ~~that~~:

(1) Files an appropriate application approved by the board;

(2) Pays an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure fee. The fees specified in this subsection may not differ from an applicant seeking licensure pursuant to s. 466.006;

(3) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(4) Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;

(5) Submits documentation that she or he has completed, or will obtain before ~~prior to~~ licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006 for the last full reporting biennium before applying for a health access dental license;

(6) Submits proof of her or his successful completion of parts I and II of the dental examination by the National Board of Dental Examiners and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;

(7) Currently holds a valid, active, dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another of the United States, the District of Columbia, or a United States territory;

(8) Has never had a license revoked from another of the United States, the District of Columbia, or a United States territory;

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(9) Has never failed the examination specified in s. 466.006, unless the applicant was reexamined pursuant to s. 466.006 and received a license to practice dentistry in this state;

(10) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank;

(11) Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and

(12) Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a).

Section 12. Notwithstanding the January 1, 2020, repeal of section 466.00671, Florida Statutes, that section is revived, reenacted, and amended to read:

466.00671 Renewal of the health access dental license.—

(1) A health access dental licensee shall apply for renewal each biennium. At the time of renewal, the licensee shall sign a statement that she or he has complied with all continuing education requirements of an active dentist licensee. The board shall renew a health access dental license for an applicant who ~~that~~:

(a) Submits documentation, as approved by the board, from the employer in the health access setting that the licensee has

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697 at all times pertinent remained an employee;

698 (b) Has not been convicted of or pled nolo contendere to,

699 regardless of adjudication, any felony or misdemeanor related to

700 the practice of a health care profession;

701 (c) Has paid a renewal fee set by the board. The fee

702 specified herein may not differ from the renewal fee adopted by

703 the board pursuant to s. 466.013. The department may provide

704 payment for these fees through the dentist's salary, benefits,

705 or other department funds;

706 (d) Has not failed the examination specified in s. 466.006

707 since initially receiving a health access dental license or

708 since the last renewal; and

709 (e) Has not been reported to the National Practitioner Data

710 Bank, unless the applicant successfully appealed to have his or

711 her name removed from the data bank.

712 (2) The board may undertake measures to independently

713 verify the health access dental licensee's ongoing employment

714 status in the health access setting.

715 Section 13. Notwithstanding the January 1, 2020, repeal of

716 section 466.00672, Florida Statutes, that section is revived and

717 reenacted to read:

718 466.00672 Revocation of health access dental license.—

719 (1) The board shall revoke a health access dental license

720 upon:

721 (a) The licensee's termination from employment from a

722 qualifying health access setting;

723 (b) Final agency action determining that the licensee has

724 violated any provision of s. 466.027 or s. 466.028, other than

725 infractions constituting citation offenses or minor violations;

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726 or

727 (c) Failure of the Florida dental licensure examination.

728 (2) Failure of an individual licensed pursuant to s.

729 466.0067 to limit the practice of dentistry to health access

730 settings as defined in s. 466.003 constitutes the unlicensed

731 practice of dentistry.

732 Section 14. Paragraph (b) of subsection (4) and paragraph

733 (a) of subsection (6) of section 466.007, Florida Statutes, are

734 amended to read:

735 466.007 Examination of dental hygienists.—

736 (4) Effective July 1, 2012, to be licensed as a dental

737 hygienist in this state, an applicant must successfully complete

738 the following:

739 (b) A practical or clinical examination approved by the

740 board. The examination shall be the Dental Hygiene Examination

741 produced by the American Board of Dental Examiners, Inc. (ADEX)

742 or its successor entity, if any, if the board finds that the

743 successor entity's clinical examination meets or exceeds the

744 provisions of this section. The board shall approve the ADEX

745 Dental Hygiene Examination if the board has attained and

746 continues to maintain representation on the ADEX House of

747 Representatives, the ADEX Dental Hygiene Examination Development

748 Committee, and such other ADEX Dental Hygiene committees as the

749 board deems appropriate through rulemaking to ensure that the

750 standards established in this section are maintained

751 organizationally. The ADEX Dental Hygiene Examination or the

752 examination produced by its successor entity is a comprehensive

753 examination in which an applicant must demonstrate skills within

754 the dental hygiene scope of practice on a live patient and any

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other components that the board deems necessary for the applicant to successfully demonstrate competency for the purpose of licensure. ~~The ADEX Dental Hygiene Examination or the examination by the successor entity administered in this state shall be graded by dentists and dental hygienists licensed in this state who are employed by the department for this purpose.~~

(6) (a) A passing score on the ADEX Dental Hygiene Examination administered out of state ~~must~~ shall be considered the same as a passing score for the ADEX Dental Hygiene Examination administered in this state ~~and graded by licensed dentists and dental hygienists.~~

Section 15. Subsections (9) through (15) are added to section 466.017, Florida Statutes, to read:

466.017 Prescription of drugs; anesthesia.-

(9) Any adverse incident that occurs in an office maintained by a dentist must be reported to the department. The required notification to the department must be submitted in writing by certified mail and postmarked within 48 hours after the incident occurs.

(10) A dentist practicing in this state must notify the board in writing by certified mail within 48 hours after any adverse incident that occurs in the dentist's outpatient facility. A complete written report must be filed with the board within 30 days after the incident occurs.

(11) Any certified registered dental hygienist administering local anesthesia must notify the board in writing by registered mail within 48 hours after any adverse incident that was related to or the result of the administration of local anesthesia. A complete written report must be filed with the

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board within 30 days after the mortality or other adverse incident.

(12) A failure by the dentist or dental hygienist to timely and completely comply with all the reporting requirements in this section is the basis for disciplinary action by the board pursuant to s. 466.028(1).

(13) The department shall review each adverse incident and determine whether it involved conduct by a health care professional subject to disciplinary action, in which case s. 456.073 applies. Disciplinary action, if any, shall be taken by the board under which the health care professional is licensed.

(14) As used in subsections (9)-(13), the term "adverse incident" means any mortality that occurs during or as the result of a dental procedure, or an incident that results in a temporary or permanent physical or mental injury that requires hospitalization or emergency room treatment of a dental patient which occurs during or as a direct result of the use of general anesthesia, deep sedation, moderate sedation, pediatric moderate sedation, oral sedation, minimal sedation (anxiolysis), nitrous oxide, or local anesthesia.

(15) The board may adopt rules to administer this section.

Section 16. Section 466.031, Florida Statutes, is amended to read:

466.031 "Dental laboratories ~~laboratory~~" defined.-

(1) As used in this chapter, the term "dental laboratory" ~~as used in this chapter:~~

~~(1)~~ includes any person, firm, or corporation ~~that who~~ performs for a fee of any kind, gratuitously, or otherwise, directly or through an agent or an employee, by any means or

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method, or ~~who in any way~~ supplies or manufactures artificial substitutes for the natural teeth; ~~or who~~ furnishes, supplies, constructs, or reproduces or repairs any prosthetic denture, bridge, or appliance to be worn in the human mouth; or ~~who~~ in any way represents ~~holds~~ itself ~~out~~ as a dental laboratory.

~~(2) The term does not include a~~ Excludes any dental laboratory technician who constructs or repairs dental prosthetic appliances in the office of a licensed dentist exclusively for that ~~such~~ dentist ~~only and~~ under her or his supervision and work order.

(2) An employee or independent contractor of a dental laboratory, acting as an agent of that dental laboratory, may engage in onsite consultation with a licensed dentist during a dental procedure.

Section 17. Section 466.036, Florida Statutes, is amended to read:

466.036 Information; periodic inspections; equipment and supplies.—The department may require from the applicant for a registration certificate to operate a dental laboratory any information necessary to carry out the purpose of this chapter, including proof that the applicant has the equipment and supplies necessary to operate as determined by rule of the department, and shall require periodic inspection of all dental laboratories operating in this state at least once each biennial registration period. Such inspections ~~must~~ shall include, but need not be limited to, inspection of sanitary conditions, equipment, supplies, and facilities on the premises. The department shall specify dental equipment and supplies that are not allowed ~~permitted~~ in a registered dental laboratory.

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Section 18. Subsection (1) of section 468.701, Florida Statutes, is amended to read:

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

(1) "Athletic trainer" means a person licensed under this part who has met the requirements of ~~under~~ this part, including the education requirements established as set forth by the Commission on Accreditation of Athletic Training Education or its successor organization and necessary credentials from the Board of Certification. ~~An individual who is licensed as an athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.~~

Section 19. Section 468.707, Florida Statutes, is amended to read:

468.707 Licensure requirements.—Any person desiring to be licensed as an athletic trainer shall apply to the department on a form approved by the department. An applicant shall also provide records or other evidence, as determined by the board, to prove he or she has met the requirements of this section. The department shall license each applicant who:

(1) Has completed the application form and remitted the required fees.

(2) ~~For a person who applies on or after July 1, 2016,~~ Has submitted to background screening pursuant to s. 456.0135. The board may require a background screening for an applicant whose license has expired or who is undergoing disciplinary action.

(3) (a) Has obtained, at a minimum, a bachelor's

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871 ~~baccalaureate or higher~~ degree from a college or university
 872 professional athletic training degree program accredited by the
 873 Commission on Accreditation of Athletic Training Education or
 874 its successor organization recognized and approved by the United
 875 States Department of Education or the Commission on Recognition
 876 of Postsecondary Accreditation, approved by the board, or
 877 recognized by the Board of Certification, and has passed the
 878 national examination to be certified by the Board of
 879 Certification; ~~or-~~

880 (b)(4) Has obtained, at a minimum, a bachelor's degree, has
 881 completed the Board of Certification internship requirements,
 882 and holds ~~If graduated before 2004, has~~ a current certification
 883 from the Board of Certification.

884 (4)(5) Has current certification in both cardiopulmonary
 885 resuscitation and the use of an automated external defibrillator
 886 set forth in the continuing education requirements as determined
 887 by the board pursuant to s. 468.711.

888 (5)(6) Has completed any other requirements as determined
 889 by the department and approved by the board.

890 Section 20. Subsection (3) of section 468.711, Florida
 891 Statutes, is amended to read:

892 468.711 Renewal of license; continuing education.—

893 (3) If initially licensed after January 1, 1998, the
 894 licensee must be currently certified by the Board of
 895 Certification or its successor agency and maintain that
 896 certification in good standing without lapse.

897 Section 21. Section 468.713, Florida Statutes, is amended
 898 to read:

899 468.713 Responsibilities of athletic trainers.—

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900 (1) An athletic trainer shall practice under the direction
 901 of a physician licensed under chapter 458, chapter 459, chapter
 902 460, or otherwise authorized by Florida law to practice
 903 medicine. The physician shall communicate his or her direction
 904 through oral or written prescriptions or protocols as deemed
 905 appropriate by the physician for the provision of services and
 906 care by the athletic trainer. An athletic trainer shall provide
 907 service or care in the manner dictated by the physician.

908 (2) An athletic trainer shall work within his or her
 909 allowable scope of practice as specified in board rule under s.
 910 468.705. An athletic trainer may not provide, offer to provide,
 911 or represent that he or she is qualified to provide any care or
 912 services that he or she lacks the education, training, or
 913 experience to provide or that he or she is otherwise prohibited
 914 by law from providing.

915 Section 22. Subsection (2) of section 468.723, Florida
 916 Statutes, is amended to read:

917 468.723 Exemptions.—This part does not prohibit ~~prevent~~ or
 918 restrict:

919 (2) An athletic training student acting under the direct
 920 supervision of a licensed athletic trainer. For purposes of this
 921 subsection, "direct supervision" means the physical presence of
 922 an athletic trainer so that the athletic trainer is immediately
 923 available to the athletic training student and able to intervene
 924 on behalf of the athletic training student. The supervision must
 925 comply with board rule in accordance with the standards set
 926 forth by the Commission on Accreditation of Athletic Training
 927 Education or its successor.

928 Section 23. Subsections (1), (3), and (4) of section

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468.803, Florida Statutes, are amended to read:

468.803 License, registration, and examination requirements.—

(1) The department shall issue a license to practice orthotics, prosthetics, or pedorthics, or a registration for a resident to practice orthotics or prosthetics, to qualified applicants. Licenses to practice shall be granted independently ~~in~~ orthotics, prosthetics, or pedorthics must be granted independently, but a person may be licensed in more than one such discipline, and a prosthetist-orthotist license may be granted to persons meeting the requirements for licensure both as a prosthetist and as an orthotist license. Registrations to practice shall be granted independently in orthotics or prosthetics must be granted independently, and a person may be registered in both disciplines fields at the same time or jointly in orthotics and prosthetics as a dual registration.

(3) A person seeking to attain the ~~required~~ orthotics or prosthetics experience required for licensure in this state must be approved by the board and registered as a resident by the department. Although a registration may be held in both disciplines practice fields, for independent registrations the board may shall not approve a second registration until at least 1 year after the issuance of the first registration. Notwithstanding subsection (2), a person an applicant who has been approved by the board and registered by the department in one discipline practice field may apply for registration in the second discipline practice field without an additional state or national criminal history check during the period in which the first registration is valid. Each independent registration or

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dual registration is valid for 2 years after ~~from~~ the date of issuance unless otherwise revoked by the department upon recommendation of the board. The board shall set a registration fee not to exceed \$500 to be paid by the applicant. A registration may be renewed once by the department upon recommendation of the board for a period no longer than 1 year, as such renewal is defined by the board by rule. The ~~registration~~ renewal fee may shall not exceed one-half the current registration fee. To be considered by the board for approval of registration as a resident, the applicant must have one of the following:

(a) A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs. ~~or, at~~

(b) A minimum ~~of~~ a bachelor's degree from a regionally accredited college or university and a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board. ~~or~~

(c) A minimum of a bachelor's degree from a regionally accredited college or university and a dual certificate in both orthotics and prosthetics from programs recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

~~(b) A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a~~

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~~minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.~~

(4) The department may develop and administer a state examination for an orthotist or a prosthetist license, or the board may approve the existing examination of a national standards organization. The examination must be predicated on a minimum of a baccalaureate-level education and formalized specialized training in the appropriate field. Each examination must demonstrate a minimum level of competence in basic scientific knowledge, written problem solving, and practical clinical patient management. The board shall require an examination fee not to exceed the actual cost to the board in developing, administering, and approving the examination, which fee must be paid by the applicant. To be considered by the board for examination, the applicant must have:

(a) For an examination in orthotics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics internship of 1 year of qualified

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experience, as determined by the board, or an orthotic residency or dual residency program recognized by the board.

(b) For an examination in prosthetics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved prosthetics internship of 1 year of qualified experience, as determined by the board, or a prosthetic residency or dual residency program recognized by the board.

Section 24. Subsection (5) of section 480.033, Florida Statutes, is amended to read:

480.033 Definitions.—As used in this act:

(5) "Apprentice" means a person approved by the board to study colonic irrigation ~~massage~~ under the instruction of a licensed massage therapist practicing colonic irrigation.

Section 25. Subsections (1) and (2) of section 480.041, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(1) Any person is qualified for licensure as a massage therapist under this act who:

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(a) Is at least 18 years of age or has received a high school diploma or high school equivalency diploma;

(b) Has completed a course of study at a board-approved massage school ~~or has completed an apprenticeship program~~ that meets standards adopted by the board; and

(c) Has received a passing grade on a national ~~an~~ examination designated ~~administered~~ by the board ~~department~~.

(2) Every person desiring to be examined for licensure as a massage therapist must ~~shall~~ apply to the department in writing upon forms prepared and furnished by the department. Such applicants are ~~shall be~~ subject to the ~~provisions of s.~~ 480.046(1). ~~Applicants may take an examination administered by the department only upon meeting the requirements of this section as determined by the board.~~

(8) A person issued a license as a massage apprentice before July 1, 2020, may continue that apprenticeship and perform massage therapy as authorized under that license until it expires. Upon completion of the apprenticeship, which must occur before July 1, 2023, a massage apprentice may apply to the board for full licensure and be granted a license if all other applicable licensure requirements are met.

Section 26. Section 480.042, Florida Statutes, is repealed.

Section 27. Subsection (3) of section 490.003, Florida Statutes, is amended to read:

490.003 Definitions.—As used in this chapter:

(3)(a) ~~Prior to July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology" mean a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from:~~

~~1. An educational institution which, at the time the~~

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~~applicant was enrolled and graduated, had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and~~

~~2. A psychology program within that educational institution which, at the time the applicant was enrolled and graduated, had programmatic accreditation from an accrediting agency recognized and approved by the United States Department of Education or was comparable to such programs.~~

~~(b)~~ Effective July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology" mean a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at:

~~1. an educational institution that which, at the time the applicant was enrolled and graduated;~~

(a) ~~Had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and~~

~~(b) 2. A psychology program within that educational institution which, at the time the applicant was enrolled and graduated, Had programmatic accreditation from the American Psychological Association an agency recognized and approved by the United States Department of Education.~~

Section 28. Paragraph (b) of subsection (1) and paragraph (b) of subsection (2) of section 490.005, Florida Statutes, are amended to read:

490.005 Licensure by examination.—

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(1) Any person desiring to be licensed as a psychologist shall apply to the department to take the licensure examination. The department shall license each applicant who the board certifies has:

(b) Submitted proof satisfactory to the board that the applicant has received:

1. ~~Received~~ Doctoral-level psychological education, ~~as defined in s. 490.003(3); or~~

2. ~~Received~~ The equivalent of a doctoral-level psychological education, as defined in s. 490.003(3), from a program at a school or university located outside the United States of America ~~and Canada~~, which was officially recognized by the government of the country in which it is located as an institution or program to train students to practice professional psychology. The applicant has the burden of establishing that this requirement has the requirements of this provision have been met ~~shall be upon the applicant~~.

3. ~~Received and submitted to the board, prior to July 1, 1999, certification of an augmented doctoral-level psychological education from the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the United States Department of Education; or~~

4. ~~Received and submitted to the board, prior to August 31, 2001, certification of a doctoral-level program that at the time the applicant was enrolled and graduated maintained a standard of education and training comparable to the standard of training of programs accredited by a programmatic agency recognized and approved by the United States Department of Education. Such~~

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~~certification of comparability shall be provided by the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the United States Department of Education.~~

(2) Any person desiring to be licensed as a school psychologist shall apply to the department to take the licensure examination. The department shall license each applicant who the department certifies has:

(b) Submitted satisfactory proof to the department that the applicant:

1. Has received a doctorate, specialist, or equivalent degree from a program primarily psychological in nature and has completed 60 semester hours or 90 quarter hours of graduate study, in areas related to school psychology as defined by rule of the department, from a college or university which at the time the applicant was enrolled and graduated was accredited by an accrediting agency recognized and approved by the Council for Higher Education Accreditation or its successor organization Commission on Recognition of Postsecondary Accreditation or from an institution that which is ~~publicly recognized as~~ a member in good standing with the Association of Universities and Colleges of Canada.

2. Has had a minimum of 3 years of experience in school psychology, 2 years of which must be supervised by an individual who is a licensed school psychologist or who has otherwise qualified as a school psychologist supervisor, by education and experience, as set forth by rule of the department. A doctoral internship may be applied toward the supervision requirement.

3. Has passed an examination provided by the department.

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1161 Section 29. Subsection (1) of section 490.006, Florida
1162 Statutes, is amended to read:

1163 490.006 Licensure by endorsement.—

1164 (1) The department shall license a person as a psychologist
1165 or school psychologist who, upon applying to the department and
1166 remitting the appropriate fee, demonstrates to the department
1167 or, in the case of psychologists, to the board that the
1168 applicant:

1169 ~~(a) Holds a valid license or certificate in another state~~
1170 ~~to practice psychology or school psychology, as applicable,~~
1171 ~~provided that, when the applicant secured such license or~~
1172 ~~certificate, the requirements were substantially equivalent to~~
1173 ~~or more stringent than those set forth in this chapter at that~~
1174 ~~time; and, if no Florida law existed at that time, then the~~
1175 ~~requirements in the other state must have been substantially~~
1176 ~~equivalent to or more stringent than those set forth in this~~
1177 ~~chapter at the present time.~~

1178 (a)(b) Is a diplomate in good standing with the American
1179 Board of Professional Psychology, Inc.; or

1180 (b)(c) Possesses a doctoral degree in psychology ~~as~~
1181 ~~described in s. 490.003~~ and has at least 10 ~~20~~ years of
1182 experience as a licensed psychologist in any jurisdiction or
1183 territory of the United States within the 25 years preceding the
1184 date of application.

1185 Section 30. Subsection (6) of section 491.0045, Florida
1186 Statutes, as amended by chapter 2016-80 and chapter 2016-241,
1187 Laws of Florida, is amended to read:

1188 491.0045 Intern registration; requirements.—

1189 (6) A registration issued on or before March 31, 2017,

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1190 expires March 31, 2022, and may not be renewed or reissued. Any
1191 registration issued after March 31, 2017, expires 60 months
1192 after the date it is issued. The board may make a one-time
1193 exception from the requirements of this subsection in emergency
1194 or hardship cases, as defined by board rule, if ~~a subsequent~~
1195 ~~intern registration may not be issued unless~~ the candidate has
1196 passed the theory and practice examination described in s.
1197 491.005(1)(d), (3)(d), and (4)(d).

1198 Section 31. Subsections (3) and (4) of section 491.005,
1199 Florida Statutes, are amended to read:

1200 491.005 Licensure by examination.—

1201 (3) MARRIAGE AND FAMILY THERAPY.—Upon verification of
1202 documentation and payment of a fee not to exceed \$200, as set by
1203 board rule, plus the actual cost of ~~to the department for~~ the
1204 purchase of the examination from the Association of Marital and
1205 Family Therapy Regulatory Board, or similar national
1206 organization, the department shall issue a license as a marriage
1207 and family therapist to an applicant who the board certifies:

1208 (a) Has submitted an application and paid the appropriate
1209 fee.

1210 (b)1. Has a minimum of a master's degree with major
1211 emphasis in marriage and family therapy, ~~or a closely related~~
1212 field from a program accredited by the Commission on
1213 Accreditation for Marriage and Family Therapy Education or from
1214 a Florida university program accredited by the Council for
1215 Accreditation of Counseling and Related Educational Programs,
1216 and graduate courses approved by the Board of Clinical Social
1217 Work, Marriage and Family Therapy, and Mental Health Counseling
1218 ~~has completed all of the following requirements:~~

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1219 a. ~~Thirty-six semester hours or 48 quarter hours of~~
 1220 ~~graduate coursework, which must include a minimum of 3 semester~~
 1221 ~~hours or 4 quarter hours of graduate-level course credits in~~
 1222 ~~each of the following nine areas: dynamics of marriage and~~
 1223 ~~family systems; marriage therapy and counseling theory and~~
 1224 ~~techniques; family therapy and counseling theory and techniques;~~
 1225 ~~individual human development theories throughout the life cycle;~~
 1226 ~~personality theory or general counseling theory and techniques;~~
 1227 ~~psychopathology; human sexuality theory and counseling~~
 1228 ~~techniques; psychosocial theory; and substance abuse theory and~~
 1229 ~~counseling techniques. Courses in research, evaluation,~~
 1230 ~~appraisal, assessment, or testing theories and procedures;~~
 1231 ~~thesis or dissertation work; or practicums, internships, or~~
 1232 ~~fieldwork may not be applied toward this requirement.~~

1233 b. ~~A minimum of one graduate-level course of 3 semester~~
 1234 ~~hours or 4 quarter hours in legal, ethical, and professional~~
 1235 ~~standards issues in the practice of marriage and family therapy~~
 1236 ~~or a course determined by the board to be equivalent.~~

1237 c. ~~A minimum of one graduate-level course of 3 semester~~
 1238 ~~hours or 4 quarter hours in diagnosis, appraisal, assessment,~~
 1239 ~~and testing for individual or interpersonal disorder or~~
 1240 ~~dysfunction; and a minimum of one 3-semester-hour or 4-quarter-~~
 1241 ~~hour graduate-level course in behavioral research which focuses~~
 1242 ~~on the interpretation and application of research data as it~~
 1243 ~~applies to clinical practice. Credit for thesis or dissertation~~
 1244 ~~work, practicums, internships, or fieldwork may not be applied~~
 1245 ~~toward this requirement.~~

1246 d. ~~A minimum of one supervised clinical practicum,~~
 1247 ~~internship, or field experience in a marriage and family~~

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1248 ~~counseling setting, during which the student provided 180 direct~~
 1249 ~~client contact hours of marriage and family therapy services~~
 1250 ~~under the supervision of an individual who met the requirements~~
 1251 ~~for supervision under paragraph (c). This requirement may be met~~
 1252 ~~by a supervised practice experience which took place outside the~~
 1253 ~~academic arena, but which is certified as equivalent to a~~
 1254 ~~graduate-level practicum or internship program which required a~~
 1255 ~~minimum of 180 direct client contact hours of marriage and~~
 1256 ~~family therapy services currently offered within an academic~~
 1257 ~~program of a college or university accredited by an accrediting~~
 1258 ~~agency approved by the United States Department of Education, or~~
 1259 ~~an institution which is publicly recognized as a member in good~~
 1260 ~~standing with the Association of Universities and Colleges of~~
 1261 ~~Canada or a training institution accredited by the Commission on~~
 1262 ~~Accreditation for Marriage and Family Therapy Education~~
 1263 ~~recognized by the United States Department of Education.~~
 1264 ~~Certification shall be required from an official of such~~
 1265 ~~college, university, or training institution.~~

1266 2. If the course title that ~~which~~ appears on the
 1267 applicant's transcript does not clearly identify the content of
 1268 the coursework, the applicant shall ~~be required to~~ provide
 1269 additional documentation, including, but not limited to, a
 1270 syllabus or catalog description published for the course.

1271
 1272 The required master's degree must have been received in an
 1273 institution of higher education that, ~~which~~ at the time the
 1274 applicant graduated, ~~was~~ fully accredited by a regional
 1275 accrediting body recognized by the Commission on Recognition of
 1276 Postsecondary Accreditation ~~or~~, publicly recognized as a member

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1277 in good standing with the Association of Universities and
 1278 Colleges of Canada, or an institution of higher education
 1279 located outside the United States and Canada, which, at the time
 1280 the applicant was enrolled and at the time the applicant
 1281 graduated, maintained a standard of training substantially
 1282 equivalent to the standards of training of those institutions in
 1283 the United States which are accredited by a regional accrediting
 1284 body recognized by the Commission on Recognition of
 1285 Postsecondary Accreditation. Such foreign education and training
 1286 must have been received in an institution or program of higher
 1287 education officially recognized by the government of the country
 1288 in which it is located as an institution or program to train
 1289 students to practice as professional marriage and family
 1290 therapists or psychotherapists. The applicant has the burden of
 1291 establishing that the requirements of this provision have been
 1292 met ~~shall be upon the applicant~~, and the board shall require
 1293 documentation, such as, ~~but not limited to~~, an evaluation by a
 1294 foreign equivalency determination service, as evidence that the
 1295 applicant's graduate degree program and education were
 1296 equivalent to an accredited program in this country. An
 1297 applicant with a master's degree from a program that ~~which~~ did
 1298 not emphasize marriage and family therapy may complete the
 1299 coursework requirement in a training institution fully
 1300 accredited by the Commission on Accreditation for Marriage and
 1301 Family Therapy Education recognized by the United States
 1302 Department of Education.

1303 (c) Has had at least 2 years of clinical experience during
 1304 which 50 percent of the applicant's clients were receiving
 1305 marriage and family therapy services, which must be at the post-

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1306 master's level under the supervision of a licensed marriage and
 1307 family therapist with at least 5 years of experience, or the
 1308 equivalent, who is a qualified supervisor as determined by the
 1309 board. An individual who intends to practice in Florida to
 1310 satisfy the clinical experience requirements must register
 1311 pursuant to s. 491.0045 before commencing practice. If a
 1312 graduate has a master's degree with a major emphasis in marriage
 1313 and family therapy or a closely related field which ~~that~~ did not
 1314 include all of the coursework required by subparagraph (b)1.
 1315 ~~under sub-subparagraphs (b)1.a.-c.~~, credit for the post-master's
 1316 level clinical experience may ~~shall~~ not commence until the
 1317 applicant has completed a minimum of 10 of the courses required
 1318 by subparagraph (b)1. ~~under sub-subparagraphs (b)1.a.-c.~~, as
 1319 determined by the board, and at least 6 semester hours or 9
 1320 quarter hours of the course credits must have been completed in
 1321 the area of marriage and family systems, theories, or
 1322 techniques. Within the 2 ~~3~~ years of required experience, the
 1323 applicant shall provide direct individual, group, or family
 1324 therapy and counseling, ~~to include the following categories of~~
 1325 cases including those involving ~~unmarried dyads, married~~
 1326 couples, separating and divorcing couples, and family groups
 1327 that include ~~including~~ children. A doctoral internship may be
 1328 applied toward the clinical experience requirement. A licensed
 1329 mental health professional must be on the premises when clinical
 1330 services are provided by a registered intern in a private
 1331 practice setting.

1332 (d) Has passed a theory and practice examination provided
 1333 by the department ~~for this purpose~~.

1334 (e) Has demonstrated, in a manner designated by board rule

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of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

~~(f)~~

For the purposes of dual licensure, the department shall license as a marriage and family therapist any person who meets the requirements of s. 491.0057. Fees for dual licensure may ~~shall~~ not exceed those stated in this subsection.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed \$200, as set by board rule, plus the actual per applicant cost of ~~to the~~ department for purchase of the examination from the National Board for Certified Counselors or its successor Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors or a similar national organization, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b)1. Has a minimum of an earned master's degree from a mental health counseling program accredited by the Council for the Accreditation of Counseling and Related Educational Programs which ~~that~~ consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling which ~~that~~ is not accredited by the Council for the Accreditation of Counseling and Related

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Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet all of the following requirements:

a. Thirty-three semester hours or 44 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling in community settings; and substance abuse. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework addressing diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The graduate program must have emphasized the common core curricular experience in legal, ethical, and professional standards issues in the practice of mental health counseling, which includes goals, objectives, and practices of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certifications and

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licensing, and the role identity and professional obligations of mental health counselors. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

c. The equivalent, as determined by the board, of at least 700 1,000 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. Has provided additional documentation if a the course title that ~~which~~ appears on the applicant's transcript does not clearly identify the content of the coursework. The ~~applicant~~ applicant ~~shall be required to provide additional documentation must~~ include, including, but is not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education that, which at the time the applicant graduated, was fully accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or Commission on Recognition of Postsecondary Accreditation, publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada, or an institution of higher education located outside the United States and Canada, which, at the time the applicant was enrolled

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and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The applicant has the burden of establishing that the requirements of this provision have been met ~~shall be upon the applicant~~, and the board shall require documentation, such as, ~~but not limited to~~, an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Has had at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If

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a graduate has a master's degree with a major related to the practice of mental health counseling ~~which that~~ did not include all the coursework required under sub-subparagraphs (b)1.a. and b. (b)1.a.-b., credit for the post-master's level clinical experience ~~may shall~~ not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b. (b)1.a.-b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department for this purpose.

(e) Has demonstrated, in a manner designated by board rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

Section 32. Paragraph (b) of subsection (1) of section 491.006, Florida Statutes, is amended to read:

491.006 Licensure or certification by endorsement.—

(1) The department shall license or grant a certificate to a person in a profession regulated by this chapter who, upon applying to the department and remitting the appropriate fee, demonstrates to the board that he or she:

(b)1. Holds an active valid license to practice and has actively practiced the licensed profession ~~for which licensure is applied~~ in another state for 3 of the last 5 years immediately preceding licensure;—

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~~2. Meets the education requirements of this chapter for the profession for which licensure is applied.~~

~~2.3-~~ Has passed a substantially equivalent licensing examination in another state or has passed the licensure examination in this state in the profession for which the applicant seeks licensure; ~~and-~~

~~3.4-~~ Holds a license in good standing, is not under investigation for an act that would constitute a violation of this chapter, and has not been found to have committed any act that would constitute a violation of this chapter.

The fees paid by any applicant for certification as a master social worker under this section are nonrefundable.

Section 33. Subsection (3) of section 491.007, Florida Statutes, is amended to read:

491.007 Renewal of license, registration, or certificate.—

~~(3) The board or department shall prescribe by rule a method for the biennial renewal of an intern registration at a fee set by rule, not to exceed \$100.~~

Section 34. Subsection (2) of section 491.009, Florida Statutes, is amended to read:

491.009 Discipline.—

(2) The board department, or, in the case of certified master social workers ~~psychologists~~, the department board, may enter an order denying licensure or imposing any of the penalties authorized in s. 456.072(2) against any applicant for licensure or any licensee who violates ~~is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).~~

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1509 Section 35. Subsection (2) of section 491.0046, Florida
 1510 Statutes, is amended to read:
 1511 491.0046 Provisional license; requirements.-
 1512 (2) The department shall issue a provisional clinical
 1513 social worker license, provisional marriage and family therapist
 1514 license, or provisional mental health counselor license to each
 1515 applicant who the board certifies has:
 1516 (a) Completed the application form and remitted a
 1517 nonrefundable application fee not to exceed \$100, as set by
 1518 board rule; and
 1519 (b) Earned a graduate degree in social work, a graduate
 1520 degree with a major emphasis in marriage and family therapy or a
 1521 closely related field, or a graduate degree in a major related
 1522 to the practice of mental health counseling; and
 1523 (c) ~~Has~~ Met the following minimum coursework requirements:
 1524 1. For clinical social work, a minimum of 15 semester hours
 1525 or 22 quarter hours of the coursework required by s.
 1526 491.005(1)(b)2.b.
 1527 2. For marriage and family therapy, 10 of the courses
 1528 required by s. 491.005(3)(b)1. ~~s. 491.005(3)(b)1.a.-c.~~, as
 1529 determined by the board, and at least 6 semester hours or 9
 1530 quarter hours of the course credits must have been completed in
 1531 the area of marriage and family systems, theories, or
 1532 techniques.
 1533 3. For mental health counseling, a minimum of seven of the
 1534 courses required under s. 491.005(4)(b)1.a.-c.
 1535 Section 36. Subsection (11) of section 945.42, Florida
 1536 Statutes, is amended to read:
 1537 945.42 Definitions; ss. 945.40-945.49.-As used in ss.

Page 53 of 54

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

25-00375A-20

2020230__

1538 945.40-945.49, the following terms shall have the meanings
 1539 ascribed to them, unless the context shall clearly indicate
 1540 otherwise:
 1541 (11) "Psychological professional" means a behavioral
 1542 practitioner who has an approved doctoral degree in psychology
 1543 as defined in s. 490.003(3) ~~s. 490.003(3)(b)~~ and is employed by
 1544 the department or who is licensed as a psychologist pursuant to
 1545 chapter 490.
 1546 Section 37. This act shall take effect July 1, 2020.

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

THE FLORIDA SENATE
APPEARANCE RECORD

10/15/19*Meeting Date*

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

230*Bill Number (if applicable)*367440*Amendment Barcode (if applicable)*Topic Medical faculty certificateName Mat ForrestJob Title LobbyistAddress 201 E. Park Ave.*Street*Tallahassee*City*FL*State*32301*Zip*Phone 850-577-0444Email mat@ballardpartners.comSpeaking: ☐ For ☐ Against ☐ InformationWaive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)Representing Nova Southeastern UniversityAppearing at request of Chair: ☐ Yes ☒ NoLobbyist 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)

10/15/19
Meeting Date

230
Bill Number (if applicable)
952710
Amendment Barcode (if applicable)

Topic _____

Name Mary Thomas

Job Title Ass Gen. Counsel

Address 1430 Piedmont Dr E

Street

TLH

City

FL

State

32308

Zip

Phone 850 2246496

Email MThomas@f1medical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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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)

10-15-19
Meeting Date

SB 230
Bill Number (if applicable)

932710
Amendment Barcode (if applicable)

Topic _____

Name TERRY MEEK

Job Title _____

Address P O 13441
Street

Phone 850-893-

TLH FL 32317
City State Zip

Email _____

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Council of Florida Medical School Deans

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

10/15/19

Meeting Date

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

230

Bill Number (if applicable)

952710

Amendment Barcode (if applicable)

Topic Temporary License

Name Jared Willis

Job Title Director of Government Relations

Address 2544 Blirstone Pines Drive

Street

Tallahassee

City

FL

State

32301

Zip

Phone 8502841996

Email govaffairs@foma.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

10-15-19

Meeting Date

SB 230

Bill Number (if applicable)

284886 SA

Amendment Barcode (if applicable)

Topic EMERGENCY MEDICAL SERVICES - DOTT

Name Chief Ray Colburn

Job Title Executive Director

Address 221 Pinewood Dr
Street

Phone 407-468-6622

Tallahassee FL 32303
City State Zip

Email ray@ffca.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Fire Chiefs' Assoc.

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

10/15/19

Meeting Date

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

230

Bill Number (if applicable)

Topic ACGME

Amendment Barcode (if applicable)

Name Steve Winn

Job Title Executive Director

Address 2544 Blairstone Pines Drive

Phone 850-878-7364

Street

Tallahassee

FL

32301

Email winnsr@earthlink.net

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.

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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)

10/15/19
Meeting Date

SB 230
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable) _____

Name Chris Schoonover

Job Title _____

Address 101 E. College Ave Ste 502
Street
Tallahassee FL 32301
City State Zip

Phone 850-222-9075

Email chris@cccfla.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Dental Laboratory 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

10/14/19
Meeting Date

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

230
Bill Number (if applicable)

Topic Dept. of Health

Amendment Barcode (if applicable)

Name Corinne mixon

Job Title Lobbyist

Address 119 S. Monroe
Street

Phone 766 5795

Tally, FL 32301
City State Zip

Email corinnemixon@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Mental Health Counselors 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

Oct 15, 2019

Meeting Date

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

SB 230

Bill Number (if applicable)

Topic Dept of Health

Amendment Barcode (if applicable)

Name Joe Anne Hart

Job Title Chief Legislative Officer

Address 118 E. Jefferson St.

Street

Phone 850. 224. 1089

Tallahassee FL 32301

City

State

Zip

Email jahart@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)

CourtSmart Tag Report

Room: SB 401

Caption: Senate Health Policy Committee

Case No.:

Judge:

Type:

Started: 10/15/2019 9:00:31 AM

Ends: 10/15/2019 10:21:24 AM

Length: 01:20:54

9:00:30 AM Meeting called to order
9:00:52 AM Chair Harrell opening remarks
9:01:25 AM Roll Call - Quorum is present
9:01:29 AM Chair Harrell remarks
9:01:53 AM Tab 1 - Update on Children's Medical Services Program by the Department of Health
9:02:56 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan
9:13:02 AM Senator Cruz question
9:13:20 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:13:24 AM Chair Harrell response
9:13:44 AM Senator Berman question
9:14:11 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:14:45 AM Chair Harrell question
9:15:04 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:15:27 AM Senator Berman follow-up
9:15:41 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:15:56 AM Senator Berman follow-up
9:16:18 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:16:35 AM Chair Harrell question
9:16:50 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:17:35 AM Chair Harrell remarks
9:18:09 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:18:45 AM Chair Harrell remarks
9:18:51 AM Senator Cruz question
9:19:53 AM Cheryl Young, Director of CMS Medical Services Managed Care Plan response
9:20:46 AM Cassandra Pasley, Director of the CMS Early Steps Program
9:33:25 AM Chair Harrell question
9:33:59 AM Chair Harrell question
9:33:59 AM Cassandra Pasley, Director of the CMS Early Steps Program response
9:34:12 AM Chair Harrell question
9:34:19 AM Cassandra Pasley, Director of the CMS Early Steps Program response
9:34:36 AM Chair Harrell remarks
9:34:39 AM Chair Harrell further questions
9:34:51 AM Victoria Zepp, Chief Policy Officer, FL. Coalition for Children
9:37:46 AM Chair Harrell remarks
9:38:17 AM Senator Rouson question
9:38:45 AM Cassandra Pasley, Director of the CMS Early Steps Program response
9:39:46 AM Chair Harrell comments
9:40:14 AM Tab 2 - Interstate Medical Licensure Compact by OPPAGA
9:41:17 AM Tina Young, Senior Legislative Analyst OPPAGA
9:51:38 AM Janet Tashner, General Counsel OPPAGA
9:57:15 AM Chair Harrell remarks
9:58:59 AM Tab 3 - Prescription Drug Donation Repository Program by Senator Book
10:00:21 AM AM barcode 533618 by Senator Book
10:00:41 AM AM 533618 adopted
10:00:52 AM Senator Baxley question
10:01:02 AM Senator Book response
10:01:16 AM Public testimony
10:01:20 AM Dawn Steward waives in support
10:01:33 AM Senator Bean remarks
10:02:14 AM Chair Harrell remarks
10:02:48 AM Senator Book to close
10:02:59 AM Roll Call - SB 58

10:03:17 AM SB 58 reported favorably
10:03:22 AM Senator Harrell passes the Chair to Senator Berman
10:03:34 AM Tab 4 - SB 100, Dispensing Medicinal Drugs by Senator Harrell
10:05:04 AM Public Testimony
10:05:06 AM Cesar Grajales, Director of Coalitions, Americans for Prosperity waives in support
10:05:15 AM Dorene Barker, Associate State Director for Advocacy, AARP waives in support
10:05:27 AM Senator Cruz remarks
10:06:01 AM Senator Berman remarks
10:06:05 AM Senator Harrell to close
10:06:29 AM Closing
10:06:48 AM SB 100 reported favorably
10:07:01 AM Tab 5 - SB 230 Department of Health by Senator Harrell
10:11:36 AM AM barcode 878466 by Senator Harrell
10:11:45 AM Senator Harrell explains AM barcode 878466
10:12:42 AM AM 878466 adopted
10:12:45 AM AM barcode 367440 by Senator Harrell
10:12:51 AM Senator Harrell explains AM barcode 367440
10:13:44 AM Public Testimony AM barcode 367440
10:13:45 AM Matt Forrest, Nova Southeastern University waives in support
10:14:04 AM AM barcode 367440 adopted
10:14:08 AM AM barcode 952710 by Senator Harrell
10:14:25 AM Senator Harrell explains AM barcode 952710
10:15:31 AM Public Testimony AM barcode 952710
10:15:35 AM Jared Willis, Florida Osteopathic Medical Association waives in support
10:15:43 AM Terry Meek, Council of Florida Medical School Deans waives in support
10:15:52 AM Mary Thomas, Assistant General Counsel, Florida Medical Association waives in support
10:16:12 AM AM barcode 952710 adopted
10:16:19 AM AM barcode 641130 by Senator Harrell - take up the substitute AM in lieu of AM 641130
10:16:25 AM Take up Substitute AM barcode 284886
10:16:34 AM Senator Harrell to explain substitute AM barcode 284886
10:17:41 AM Public Testimony Substitute AM barcode 284886
10:17:43 AM Chief Ray Colburn, Executive Director, Florida Fire Chief's Association waives in support
10:18:01 AM Substitute AM barcode 284886 adopted
10:18:10 AM Public Testimony on SB 230
10:18:20 AM Steve Winn, FL. Osteopathic Medical Association
10:18:28 AM Chris Schoonover, FL. Dental Laboratory Association waives in support
10:18:42 AM Joe Anne Hart, Chief Legislative Officer, FL. Dentist Association
10:19:48 AM Corinne Mixon, FL. Mental Health Counselors Association waives in support
10:20:03 AM Senator Harrell to close
10:20:43 AM Roll Call - SB 230
10:21:00 AM SB 230 reported favorably
10:21:02 AM Chair Berman to return the chair
10:21:11 AM Senators to record vote? None.
10:21:16 AM Senator Mayfield moves we are adjourned so ordered.