Committee on Health Policy

CS/CS/HB 59 — Automated Pharmacy Systems

by Health and Human Services Committee; Health Quality Subcommittee; and Rep. Willhite and others (CS/CS/SB 708 by Rules Committee; Health Policy Committee; and Senator Hutson)

The bill expands current law to permit a licensed community pharmacy to provide outpatient pharmacy services for the dispensing of medicinal drugs through the use of an automated pharmacy system (APS) that need not be located at the same location as the community pharmacy if:

- The APS is under the supervision and control of the community pharmacy;
- The APS is housed in an indoor environment area and in a location to increase patients' access to their prescriptions, including, but not limited to:
  - Medical facilities;
  - Places of business where essential goods and commodities are sold;
  - Large employer workplaces; or
  - Locations where access to a community pharmacy is limited.
- The community pharmacy providing services through the APS notifies the Board of Pharmacy (BOP) of the location of the APS and any changes in such location;
- The APS has a mechanism that provides live, real time patient counseling by a pharmacist licensed in Florida, before the dispensing of any medicinal drug;
- The APS does not contain or dispense any controlled substance;
- The community pharmacy maintains a record of the drugs dispensed, including the identity of the pharmacist responsible for verifying the accuracy of the dosage and directions and providing patient counseling;
- The APS ensures confidentiality of personal health information; and
- The community pharmacy maintains written policies and procedures to ensure the proper, safe, and secure functioning of the APS.

A community pharmacy using an APS must annually review the policies and procedures and maintain a record of such policies and procedures for at least four years. The annual review must be documented in the community pharmacy's records and must be made available to the BOP upon request. The policies and procedures must address numerous issues relating to the operation, maintenance, filling, stocking, restocking, testing, and security of an APS, as well as the training of persons authorized to access the APS. The bill requires a community pharmacy to maintain an ongoing quality assurance program for the performance of its APS.

The bill requires that medicinal drugs stored in bulk or unit of use in an APS used for outpatient dispensing are part of the inventory of the pharmacy providing such outpatient dispensing with the APS.

The bill deletes the current-law requirement for the BOP to adopt rules governing a pharmacy's use of an APS and instead authorizes the BOP to adopt such rules.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 27-12; House 115-1

Committee on Health Policy

CS/HB 177 — Prescription Drug Donation Repository Program

by Health Care Appropriations Subcommittee and Rep. Yarborough and others (CS/SB 58 by Health Policy Committee; and Senators Book, Harrell, Stewart, and Cruz)

The bill 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 if the entities meet certain criteria, including nursing homes, hospices, hospitals, pharmacies, drug manufacturers or wholesale distributors, medical device manufacturers or suppliers, and prescribers who receive drugs or supplies directly from a manufacturer, distributor, or pharmacy;
- Requires donated prescription drugs to be approved for medical use in the U.S., be in unopened, tamper-evident packaging, and have an expiration date that is more than three months after the date of donation. Prescription drugs eligible under the program do not include controlled substances, cancer drugs, or drugs with an approved USDA risk evaluation and mitigation strategy that includes elements to assure safe use;
- Limits dispensing of prescription drugs under the program to persons who are licensed, registered, or otherwise permitted by state law;
- Authorizes health care practitioners' offices, pharmacies, hospitals, and nursing home facilities with closed drug delivery systems, and certain free clinics or nonprofit health clinics, to participate in the program as repositories. A repository may accept and dispense eligible donations to eligible patients under the program;
- Provides inspection, inventory, storage, dispensing, recordkeeping, and reporting requirements for repositories;
- Requires the DOH to maintain and publish on its website registries of all participating facilities and available donated drugs and supplies; 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.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 38-0; House 118-0

Committee on Health Policy

CS/SB 218 — Licensure Requirements for Osteopathic Physicians

by Health Policy Committee and Senator Harrell

The bill updates the osteopathic internship and residency accrediting agencies.

The bill amends s. 459.0055, F.S., to recognize the agreement between the American Osteopathic Association (AOA) and the Accreditation Council for Graduate Medical Education (ACGME). Under the agreement, both organizations have committed to improving the patient care delivered by resident and fellow physicians and to do so in clinical learning environments characterized by excellence in care, safety, and professionalism, thereby creating a single path for graduate medical education (GME) for physicians.

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.

The bill deletes statutory reference to the Board of Trustees of the Bureau of Professional Education of the AOA as an internship and residency accrediting organization during the transition to a single path for GME, while maintaining reference to the AOA, and repeals the Board of Osteopathic Medicine's authority to accredit other internship programs upon a showing of good cause.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 117-0

Committee on Health Policy

CS/SB 226 — Athletic Trainers

by Health Policy Committee and Senator Harrell

The bill 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.

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.

The bill amends the licensure requirements for an athletic trainer in s. 468.707, F.S., to create a new licensure pathway for applicants who hold a bachelor's degree, have completed the Board of Certification for athletic trainers (BOC) internship requirements, 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. A licensee will have to demonstrate the continuous good-standing of his or her BOC certification at the time of renewal.

The bill amends s. 468.723, F.S., to give 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 the Commission on Accreditation of Athletic Training Education.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 39-0; House 115-0

Committee on Health Policy

SB 348 — Florida Kidcare Program

by Senators Bean, Harrell, and Perry

The bill repeals the $1 million lifetime benefit maximum on covered expenses for a child enrolled in the Florida Healthy Kids (Healthy Kids) program. Under the bill, no child may be disenrolled from Healthy Kids because the dollar value of his or her benefits under the program has exceeded $1 million.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 115-0

Committee on Health Policy

CS/HB 389 — Practice of Pharmacy

by Health and Human Services Committee and Rep. Sirois and others (CS/SB 714 by Health Policy Committee and Senator Hutson)

The bill (Chapter 2020-7, L.O.F.) expands the scope of practice for pharmacists in two ways, by creating specified parameters under which pharmacists may:

- Enter into a collaborative pharmacy practice agreement with a physician to treat that physician's patients for chronic health conditions; and
- Test or screen for and treat minor, nonchronic health conditions for any patient who qualifies for such testing and treatment under the provisions and requirements of a written protocol with a supervising physician.

Collaborative Pharmacy Practice for Chronic Health Conditions

Under the bill, a "collaborative pharmacy practice agreement" (collaborative agreement) means a written agreement between a pharmacist who meets qualifications specified in the bill and a Florida-licensed allopathic or osteopathic physician in which the collaborating physician authorizes the pharmacist to provide specified patient care to the physician's patients named in the agreement.

The bill defines "chronic health condition" to mean arthritis, asthma, chronic obstructive pulmonary diseases, type 2 diabetes, HIV/AIDS, obesity, or any other chronic condition adopted in rule by the Board of Pharmacy (BOP) in consultation with the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM).

Before providing services under a collaborative agreement, a pharmacist must be certified by the BOP according to rules adopted by the BOP in consultation with the BOM and BOOM. Requirements for certification include minimum standards for experience and education, including completion of an initial 20-hour course providing instruction on topics such as performing patient assessments, ordering and interpreting laboratory tests, evaluating and managing diseases and health conditions, and other subjects required by the BOP. Certification also requires a pharmacist to maintain at least $250,000 in professional liability insurance coverage and to establish a system to maintain patient records for five years.

The terms and conditions of a collaborative agreement must be appropriate to the pharmacist's training, and services delegated to the pharmacist must be within the collaborating physician's scope of practice. A copy of the pharmacist's certification issued BOP must be included as an attachment to the collaborative agreement. A collaborative agreement must, among other requirements, include:

- The names of the physician's patient(s) who may be treated by the pharmacist;
- Each chronic health condition to be collaboratively managed;
- Specific drugs to be managed by the pharmacist for each patient;

- Circumstances under which the pharmacist may order, perform, or evaluate lab or clinical tests; and
- Conditions that require the pharmacist to notify the collaborating physician.

A pharmacist who enters into a collaborative agreement must submit a copy of the signed agreement to the BOP before the agreement may be implemented. A collaborative agreement will automatically terminate two years after execution if not renewed.

The bill prohibits a pharmacist from:
- Modifying or discontinuing drugs prescribed by a health care practitioner with whom he or she does not have a collaborative agreement; or
- Entering into a collaborative agreement while acting as an employee of a pharmacy without the written approval of the pharmacy owner.

The bill prohibits a physician from delegating the authority to initiate or prescribe controlled substances to a pharmacist.

A pharmacist who practices under a collaborative agreement must complete an eight-hour continuing education course approved by the BOP that addresses issues related to collaborative pharmacy practice with each biennial renewal of the pharmacist's license, in addition to continuing education requirements he or she must meet under preexisting law.

The bill requires the BOP, in consultation with the BOM and BOOM, to adopt rules to implement the bill's provisions for collaborative pharmacy practice.

Testing and Screening for and Treatment of Minor, Nonchronic Health Conditions by Pharmacists

The bill authorizes pharmacists who meet qualifications specified in the bill to test or screen for and treat minor, nonchronic health conditions within the framework of a written protocol with a supervising allopathic or osteopathic physician licensed in Florida. Under the bill, a minor, nonchronic health condition is typically a short-term condition that is generally managed with minimal treatment or self-care and includes:
- Influenza;
- Streptococcus;
- Lice;
- Skin conditions, such as ringworm and athlete's foot; and
- Minor, uncomplicated infections.

To qualify under the bill, a pharmacist must be certified by the BOP to have met certain educational requirements, including completion of a 20-hour education program approved by the BOP in consultation with the BOM and BOOM which must address patient assessments, point-of-care testing procedures, safe and effective treatments, and identification of contraindications.

A pharmacist so certified by the BOP must provide evidence of the certification to the supervising physician.

A pharmacist who tests and treats under the bill must also maintain at least $250,000 in liability coverage; furnish a patient's records, upon the patient's request, to a health care practitioner designated by a patient; and maintain patient records for five years from each patient's most recent provision of service.

The BOP is required to adopt by rule a formulary of drugs that a pharmacist may prescribe under a test-and-treat protocol for minor, nonchronic health conditions covered under the protocol. Such drugs must be approved by the federal Food and Drug Administration which are indicated for the treatment of such conditions. The formulary may not include controlled substances.

The bill provides that a pharmacist who tests and treats may use any tests that guide the diagnosis or clinical decision-making which the federal Centers for Medicare & Medicaid Services has determined qualify for a waiver under the federal Clinical Laboratory Improvement Amendments of 1988, or federal rules adopted thereunder, or any established screening procedures that can safely be performed by a pharmacist.

A written protocol between a pharmacist and supervising physician must include particular terms and conditions imposed by the supervising physician relating to the testing and screening for and treatment of minor, nonchronic health conditions. The terms and conditions must be appropriate to the pharmacist's training. A pharmacist who enters into such a protocol with a supervising physician must submit the protocol to the BOP. The protocol must include:

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

A pharmacist certified by the BOP to test and treat under the bill must complete a three-hour continuing education course approved by the BOP that addresses issue related to minor, nonchronic health conditions with each biennial renewal of the pharmacist's license, in addition to continuing education requirements he or she must meet under preexisting law.

A pharmacist providing test-and-treat services under the bill may not perform such services while acting as an employee of a pharmacy without the written approval of the pharmacy owner.

A pharmacist who tests and treats under the bill must provide a patient with written information to advise the patient to seek follow-up care from his or her primary care physician. The BOP must adopt rules for the circumstances under which such information must be provided.

A pharmacy in which a pharmacist tests and treats under the bill must prominently display signage indicating that any patient receiving testing, screening, or treatment services as authorized under the bill is advised to seek follow-up care from his or her primary care physician.

The bill provides that its test-and-treat provisions do not apply with respect to minor, nonchronic health conditions when treated with over-the-counter products.

Other Provisions

The bill:

- Provides that its two requirements for $250,000 in professional liability coverage (the first for collaborative pharmacy practice and the second for testing for and treating minor, nonchronic health conditions) are not duplicative and that coverage for either satisfies both requirements;
- Adds pharmacists who are authorized to perform or order and evaluate laboratory or clinical tests under a collaborative pharmacy practice or test-and-treat protocol, to the list of health care practitioners and facilities that, upon the diagnosis or suspicion of the existence of a disease of public health significance, must immediately report that fact to the Department of Health; and
- Amends the statutory definition of "practice of the profession of pharmacy" to conform to the bill's provisions.

These provisions became law upon approval by the Governor on March 11, 2020, and take effect July 1, 2020.
Vote: Senate 28-12; House 98-17

Committee on Health Policy

CS/CS/SB 404 — Abortion

by Rules Committee; Health Policy Committee; and Senators Stargel, Hutson, Harrell, Gruters, Mayfield, Baxley, Diaz, Albritton, and Broxson

The bill amends the Parental Notice of Abortion Act in s. 390.01114, F.S., to add consent requirements and renaming the Act as the Parental Notice of and Consent for Abortion Act.

The bill prohibits a physician from performing an abortion on a minor unless the physician has received a notarized, written consent statement with specified language signed by the minor's mother, father, or legal guardian and the physician has been presented with proof of identification by the parent or legal guardian. However, the consent requirement does not apply if:

- Notice is not required under specified exceptions to the parental notice requirement;
- The abortion is performed during a medical emergency when there is insufficient time to obtain consent;
- The parent or guardian has waived the right to consent; or
- The minor petitions the circuit court where she resides and receives a judicial waiver of parental consent. The bill applies the preexisting statutory procedures for obtaining a judicial waiver of the notice requirement to the process of obtaining a judicial waiver of the consent requirement.

The bill requires that a physician keep the consent document and proof of identification in the minor's medical record for at least seven years. The bill also authorizes a third degree felony penalty for a physician who recklessly or intentionally performs, or attempts to perform, an abortion on an unemancipated minor without the required consent but provides a defense if the minor misrepresented her age or identity under certain circumstances.

The bill also amends s. 390.0111(12), F.S., to increase the penalty from a first degree misdemeanor to a third degree felony for violating requirements established for infants born alive during or immediately after an attempted abortion.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 23-17; House 75-43

Committee on Health Policy

CS/CS/SB 406 — Public Records/Minor's Petition to Waive Consent/Abortion

by Rules Committee; Health Policy Committee; and Senator Stargel

The bill creates s. 390.01118, F.S., to make confidential and exempt from public inspection and copying any information that can be used to identify a minor who is petitioning a circuit court for a judicial waiver pursuant to the Parental Notification of and Consent for Abortion Act established in CS/CS/SB 404. Specifically, the bill provides that any such information is:

- Confidential and exempt from Art. I, s. 24(a), State Constitution, if held by a circuit court or an appellate court; and
- Confidential and exempt from s. 119.07(1), F.S., and Art. I, s. 24(a), State Constitution, if held by the office of criminal conflict and civil regional counsel or the Justice Administrative Commission.

The bill provides legislative findings that the public records exemption is a public necessity and provides that the public records exemption is subject to the Open Government Sunset Review Act and will be repealed on October 2, 2025, unless reviewed and saved from repeal by the Legislature.

If approved by the Governor, these provisions take effect on the same date as CS/CS/SB 404.
Vote: Senate 39-1; House 112-3

Committee on Health Policy

CS/HB 467 — Physical Therapy Practice

by Health and Human Services Committee and Rep. Stevenson and others (CS/CS/CS/SB 792 by Rules Committee; Banking and Insurance Committee; Health Policy Committee; and Senators Albritton and Harrell)

The bill amends several provisions within the Physical Therapy Practice Act. The bill amends the definition of "physical therapy assessment" to provide that the purpose of such assessments is for physical therapy treatment as opposed to making recommendations for treatment. The bill amends the definition of "practice of physical therapy" to add modalities of treatment while removing other modalities, including those relating to a physical therapist's performance of acupuncture, along with related restrictions and the Board of Medicine's oversight of the criteria for such acupuncture. The bill adds definitions of "dry needling" and "myofascial trigger point."

The bill provides that the practice of physical therapy does not authorize a physical therapist to practice acupuncture. The bill requires the Board of Physical Therapy Practice (Board) to establish minimum standards of practice for physical therapy relating to dry needling, including requirements for experience and education.

The bill requires the Department of Health to submit a report to the President of the Senate and the Speaker of the House of Representatives on or before December 31, 2022, detailing the number of physical therapists in the state, the number of physical therapists in the state performing dry needling, any increases or decreases in the number of physical therapists in the state by geographic area, and any adverse medical incidents as defined by the Board involving physical therapists in the state performing dry needling.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 38-1; House 119-0

Committee on Health Policy

CS/HB 559 — Institutional Formularies Established by Nursing Home Facilities

by Health and Human Services Committee and Rep. Byrd and others (SB 1020 by Senator Bean)

The bill authorizes a nursing home facility to establish and implement an institutional formulary (a list of medicinal drugs) that a pharmacist may use as a therapeutic substitution to replace a resident's prescribed medicinal drug with a chemically different drug listed in the formulary that is expected to have the same clinical effect.

The bill:

- Provides definitions, requirements, and operational parameters for a nursing home facility's implementation of an institutional formulary and for participation by prescribers and pharmacists.
- Requires participating nursing home facilities to establish a committee to develop the institutional formulary and perform quarterly monitoring of clinical outcomes when a therapeutic substitution occurs.
- Requires each prescriber to approve, for each patient, the use of, and any subsequent changes made to, an institutional formulary and allows a prescriber to opt-out of the institutional formulary with regard to a medicinal drug or class of medicinal drugs for any resident.
- Requires a nursing home facility to notify the prescriber before each therapeutic substitution using a method of communication designated by the prescriber and to document the therapeutic substitution in the resident's medical records.
- Authorizes a prescriber to prevent a therapeutic substitution for a specific prescription by indicating "NO THERAPEUTIC SUBSTITUTION" on the prescription, or by making an overt action for a prescription that is provided orally.
- Requires a nursing home to obtain informed consent from a resident, the resident's legal representative, or his or her designee as to the use of the institutional formulary for the resident. The nursing home must inform such person of the right to refuse to participate and may not take adverse action against the resident for choosing not to participate.
- Prohibits a nursing home facility from taking adverse action against a prescriber for not agreeing to use the facility's institutional formulary.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 39-0; House 116-2

Committee on Health Policy

CS/CS/HB 599 — Consultant Pharmacists

by Health and Human Services Committee; Health Quality Subcommittee and Rep. Rodriquez, A.M. (CS/CS/SB 1094 by Appropriations Committee; Health Policy Committee; and Senator Diaz)

The bill (Chapter 2020-8, L.O.F.) expands the scope of practice of consultant pharmacists. Under the bill, a pharmacist must complete additional training as required by the Board of Pharmacy to be licensed as a consultant pharmacist. A consultant pharmacist may provide medication management services in a health care facility within the framework of a written collaborative practice agreement between the pharmacist and a health care facility medical director, or a physician, podiatrist, or dentist who is authorized to prescribe medicinal drugs.

For the purpose of such authority, the bill defines the term "health care facility" to include:

- An ambulatory surgical center or hospital licensed under ch. 395, F.S.;
- An alcohol or chemical dependency treatment center licensed under ch. 397, F.S.;
- An inpatient hospice licensed under ch. 400, part IV, F.S.;
- A nursing home licensed under ch. 400, part II, F.S.;
- An ambulatory care center as defined in s. 408.07, F.S.; and
- A nursing home component under ch. 400, F.S., within a continuing care facility licensed under ch. 651, F.S.

A consultant pharmacist may only provide medication management services, conduct patient assessments, and order and evaluate laboratory or clinical testing for patients of the health care practitioner with whom the consultant pharmacist has a written collaborative practice agreement.

A written collaborative practice agreement must outline the circumstances under which the consultant pharmacist may:

- Order and evaluate laboratory or clinical tests to promote and evaluate patient health and wellness and monitor drug therapy and treatment outcomes;
- Conduct patient assessments as appropriate to evaluate and monitor drug therapy;
- Modify or discontinue medicinal drugs as outlined in the agreed-upon, patient-specific order or preapproved treatment protocol under the direction of a physician; and
- Administer medicinal drugs.

The bill prohibits a consultant pharmacist from modifying or discontinuing medicinal drugs prescribed by a health care practitioner who does not have a written collaborative practice agreement with the consultant pharmacist. The bill does not authorize a consultant pharmacist to diagnose any disease or condition.

The consultant pharmacist is also responsible for, and must maintain, all drug, patient care, and quality assurance records, and, with the collaborating practitioner, must maintain any written collaborative practice agreements which he or she has entered into and make them available upon request for inspection by the Department of Health.

This bill was approved by the Governor on March 11, 2020, and takes effect July 1, 2020.

Vote: Senate 40-0; House 115-2

Committee on Health Policy

CS/CS/HB 607 — Direct Care Workers

by Health and Human Services Committee; Health Quality Subcommittee; Rep. Pigman and others (CS/CS/SB 1676 by Appropriations Committee; Health Policy Committee; and Senator Albritton)

The bill (Chapter 2020-9, L.O.F.) expands the scope of practice, and defines relevant terms for, registered nurses (RN), certified nursing assistants (CNA), home health aides (HHA), and advanced practice registered nurses (APRN). Effective upon the bill becoming a law, the bill:

- Authorizes nursing home facilities to use paid feeding assistants who have completed a 12-hour program developed by the Agency for Health Care Administration (AHCA). The bill specifies that paid feeding assistants do not count toward a nursing home's minimum staffing standards.
- Authorizes an RN to delegate tasks, including the administration of medications, except controlled substances, to a CNA or HHA for a patient of a home health agency if the RN determines that the CNA or HHA is competent to perform the task, the task is delegable under federal law, and certain other requirements are met.
- Requires the AHCA, in consultation with the Board of Nursing (BON), to establish standards and procedures by rule that a CNA and HHA must follow when administering medication to a patient of a home health agency.
- Establishes disciplinary actions for RNs who knowingly delegate responsibilities to a person that is not qualified by training, experience, certification, or licensure to perform them.
- Requires the AHCA to establish an Excellence in Home Health Program and a Nurse Registry Excellence Program to award home health agencies and nurse registries, respectively, based on the achievement of specific standards. The AHCA must adopt rules to establish the criteria for the programs and annually evaluate the home health agencies or nurse registries that apply for the programs.
- Requires the AHCA to create a direct care workforce survey to be completed and submitted at the biennial license renewal by nursing homes, assisted living facilities, home health agencies, and homemaker and companion service providers. The AHCA must analyze the results of the survey and publish the information monthly on its website.

Effective July 1, 2020, the bill:

- Creates s. 464.0123, F.S., which authorizes an APRN to engage in "autonomous practice" in primary care, including family medicine, general pediatrics, and general internal medicine, as defined by the BON, or, if the APRN is also certified by the American College of Nurse Midwives and as a certified nurse midwife, he or she may engage in the "autonomous practice" of midwifery.
- Defines "autonomous practice" to mean advanced nursing practice by an APRN who is registered under s. 464.0123, F.S., and who is not subject to supervision by a physician or a supervisory protocol, after documenting the following with the BON:
  - An active, unencumbered license under s. 464.012, F.S.;
  - No disciplinary action against his or her license in last five years;

  - Three thousand clinical hours supervised by a physician in the past five years;
  - Completion of six college semester hours within the last five years, with three in pharmacology and three in differential diagnosis;
  - Financial responsibility to pay claims and costs arising out of the rendering of or the failure to render nursing care, treatment, or services in an amount not less than $100,000 per claim with a minimum annual aggregate of not less than $300,000; and
  - Any additional requirements the BON may impose by rule.
- Creates a nine-member Council on Advanced Practice Registered Nurse Autonomous Practice with four physicians, four experienced APRNs, and the State Surgeon General or his or her designee as chair.
- Requires an APRN registered under s. 464.0123, F.S., who wishes to remain registered to renew his or her registration, biennially, with his or her APRN license; and complete at least 10 hours of continuing education approved by the BON, in addition to completing the 30 hours of continuing education requirements established by BON rule, regardless of whether the registrant is otherwise required to complete this requirement. However, if the initial renewal period occurs before January 1, 2021, a registrant is not required to complete these continuing education requirements until the following biennial renewal period.
- Requires the Department of Health (DOH) to conspicuously distinguish an APRN registered under s. 464.0123, F.S., on the registrant's practitioner profile.
- Requires an APRN registered under s. 464.0123, F.S., and practicing autonomously to disclose to new patients in writing the nature of autonomous practice at the practitioner's initial visit with the patient.
- Requires an APRN registered under s. 464.0123, F.S., and practicing autonomously to report to the DOH defined adverse incidents within 15 days by certified mail.
- Creates additional grounds for discipline for APRNs registered under s. 464.0123, F.S., and practicing autonomously, including:
  - Paying or receiving any commission, bonus, kickback, or rebate from, or engaging in any split-fee arrangement with a health care practitioner, organization, agency, or person, directly or implicitly, for referring patients to providers of health care goods or services;
  - Exercising undue influence on a relationship with a patient for purposes of engaging a patient in sexual activity.
  - Making deceptive, untrue, or fraudulent representations, or employing a trick or scheme, in advanced or specialized nursing practice.
  - Soliciting patients by the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct;
  - Failing to keep legible medical records that identify the APRN who is responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient;
  - Exercising undue influence on a patient to exploit the patient for financial gain of the APRN or a third party;

  - Performing unauthorized professional services, except as provided in ss. 766.103 or 768.13, F.S.;
  - Performing any procedure or prescribing any therapy that, by the prevailing standards of advanced or specialized nursing practice in the community, would constitute experimentation on a human subject, without first obtaining full, informed, and written consent;
  - Delegating professional responsibilities to a person not qualified by training, experience, or licensure to perform such responsibilities when the APRN knows, or should have known, the person is not qualified;
  - Committing, or conspiring to commit, an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;
  - Advertising or holding himself or herself out as having certification in a specialty that he or she has not received;
  - Failing to comply with ss. 381.026 and 381.0261, F.S., relating to providing patients with information about their rights and how to file a complaint; and
  - Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.
- Prohibits a major medical, group, blanket, or franchise health insurance policy, small employer health benefit plan, or health maintenance organization contract, any of which is delivered, issued, or renewed on or after January 1, 2021, from requiring an insured or subscriber, as applicable, to receive services from an APRN registered under s. 464.0123, F.S., instead of a physician.
- Amends the Health Care Education Reimbursement and Loan Repayment Program and adds APRNs registered to practice autonomously to the list of health care practitioners who may participate. The bill requires the DOH, from the funds available for the program, to make payments of up to $15,000 per year to such APRNs who demonstrate, according to rules of the Department of Education, active employment providing primary care services in a public health program, in independent practice, or a group practice that serves Medicaid recipients and other low-income patients and that is located in a primary care health professional shortage area, as defined in the bill. Only the costs of tuition, books, medical equipment and supplies, uniforms, and living expenses may be covered.
- Appropriates for the 2020-2021 fiscal year:
  - The sum of $5 million in recurring funds from the General Revenue Fund to the DOH for the Health Care Education Reimbursement and Loan Repayment Program for APRNs registered under s. 464.0123, F.S.;
  - Funds from the DOH's Medical Quality Assurance Trust Fund for the DOH to hire 3.5 full-time equivalent (FTE) positions for the purpose of implementing s. 464.0123, F.S., relating to the registration and regulation of APRN autonomous practice; and
  - Funds from the AHCA's Health Care Trust Fund for the AHCA to hire two FTE positions for the purpose of implementing the Excellence in Home Health Program, the Nurse Registry Excellence Program, and the direct care workforce survey, all of which are created under the bill.

The bill became law upon approval of the Governor on March 11, 2020.
Vote: Senate 30-10; House 107-8

Committee on Health Policy

CS/CS/CS/HB 713 — Health Regulation

by Health and Human Services Committee; Health Care Appropriations Subcommittee; Health Quality Subcommittee; and Rep. Rodriquez, A.M. (CS/CS/CS/SB 230 by Rules Committee; Appropriations Committee; Health Policy Committee; and Senator Harrell)

The bill makes numerous updates and changes to programs and health care professions regulated under the Department of Health (DOH) or the Agency for Health Care Administration (AHCA). The bill:

- Provides that the statewide medical director for child protection reports directly to the DOH's deputy secretary in charge of the state's Children's Medical Services Program and the medical director of each child protection teams reports directly to the statewide medical director;
- Substitutes the term "human immunodeficiency virus" (HIV) in place of "acquired immune deficiency syndrome" (AIDS) to authorize the DOH to broaden the scope of the its 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, and to encourage qualified physicians to relocate to Florida and practice in medically underserved and rural areas;
- Increases the period of time that certain cancer centers may continue to participate in the Florida Consortium of National Cancer Institute Centers Program while seeking National Cancer Institute designation as a cancer center or a comprehensive cancer, until June 30, 2024;
- Modifies the DOH's rulemaking authority pertaining to minimal standards governing ground ambulance and vehicle equipment and supplies for basic and advanced life support and for ground ambulance and vehicle design and construction;
- Defines "useful beam" radiation as that portion of a radiation beam designed to focus on a specific target and specifies the requirements for the maintenance and operation of a radiation machine, as well as the conditions for use on humans;
- Requires an applicant for a health care professional license to provide his or her date of birth on the application;
- 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;
- Creates an exception to the 15-percent cap for self-referral for diagnostic imaging services normally imposed on solo or group practice settings for group practice entities that own an accountable care organization or an entity operating under an advanced alternative payment model, according to federal regulations, if such entity provides diagnostic imaging services and has more than 30,000 patients enrolled per year;

- Requires the AHCA to create a webpage dedicated to providing information to patients and families about direct care workers, including types, services, and relative relationships with patients;
- Repeals a health care practitioner's failure to repay student loans as grounds for discipline by the DOH;
- Authorizes the DOH to issue medical faculty certificates to certain full-time faculty members of Nova Southeastern University and Lake Erie College of Osteopathic Medicine;
- Repeals the requirement that the Board of Medicine (BOM) conduct a triennial review of organizations that board-certify physicians in dermatology;
- Revises the composition of the Council on Physician Assistants, under the BOM, from four physicians and one physician assistant, to two physicians and three physician assistants;
- Revises the requirements for osteopathic internships and residencies to include those accredited by the Accreditation Council for Graduate Medical Education;
- Deregulates registered chiropractic assistants;
- Effective upon the bill becoming a law, extends the sunset of the statutory requirement for the Florida Center for Nursing 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;
- Effective upon the bill becoming a law, allows a nursing education program seeking accreditation to apply to the Board of Nursing (BON) for a single extension of not more than two years if the program meets specific criteria and grants the BON rulemaking authority on criteria to qualify for the extension;
- Grants rulemaking authority to the BON to establish standards of practice, including discipline, 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 that dental and dental hygienist licensure examinations must be graded by Florida-licensed dentists and dental hygienists;
- Effective upon the bill becoming a law and applying retroactively to January 1, 2020, revives, reenacts, and amends statutory provisions relating to health access dental licenses, notwithstanding their sunset on January 1, 2020;
- Requires dentists and dental hygienists to report adverse incidents to the Board of Dentistry (BOD) and gives the BOD rulemaking 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 duel registration;
- Revises massage therapy licensure requirements to:
  - Repeal Board of Massage Therapy (BMT) departmental examinations and require a BMT-specified national examination;
  - Eliminate massage apprenticeships as a path to licensure by 2023; and
  - Revise 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 education, clinical, and licensure requirements for marriage and family therapists and licensed mental health counselors, including updating the program accrediting agencies;
- Defines the term "surf pool" to mean a pool that is designed to generate waves for surfing on a surfboard or an analogous surfing device intended for sport;
- Exempts surf pools larger than four acres from supervision as a public swimming or bathing facility by the DOH, if the surf pool is permitted by a local government special use permit in which the local government asserts regulatory authority over the construction of the surf pool and, in consultation with the DOH, establishes through the local government's special use permitting process the conditions for the surf pool's operation, water quality, and necessary lifesaving equipment;
- Adds a charge of battery of a vulnerable adult or a patient or resident of a hospital, nursing home, assisted living facility, or other assisted care community to the list of disqualifying offenses under a required level 2 background screening of health care practitioners and employees of health care facilities, regardless of adjudication; and
- Deletes obsolete language and makes technical and conforming changes.

If approved by the Governor, and except as otherwise expressly provided in the bill, the provisions of the bill take effect July 1, 2020.
Vote: Senate 37-0; House 110-0

Committee on Health Policy

CS/CS/HB 731 — Agency for Health Care Administration

by Health and Human Services Committee; Health Market Reform Subcommittee; and Rep. Perez (CS/CS/SB 1726 by Appropriations Committee; Health Policy Committee; and Senator Bean)

The bill addresses statutory authority and duties of the Agency for Health Care Administration (AHCA) relating to the regulation of health care facilities and providers. The bill:

- Extends until June 30, 2024, the deadline for Florida-based cancer centers seeking NCI-designation to achieve such designation, in order to continue participating in the Florida Consortium of National Cancer Institute Centers Program.
- Modifies annual birth center reporting to the AHCA.
- Removes outdated language relating to certificate of need, to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee.
- Reinstates the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries.
- Provides, by legislative fiat, rural hospital status to hospitals that were licensed as rural hospitals during the 2010-2011 or 2011-2012 fiscal years, regardless of whether such hospitals continue to qualify for rural status under statutory criteria. Under preexisting law, such legislative fiat would expire July 1, 2021. Under the bill, the deadline is extended through June 30, 2025.
- Repeals an unenforceable annual assessment from ambulatory surgical centers that was ruled unconstitutional.
- Removes provisions requiring fixed inspection time frames for nursing home facilities, hospices, assisted living facilities, and adult family care homes.
- Revises definitions and licensure requirements related to home health agencies.
- Creates an exemption to health care clinic licensure for federally certified providers.
- Removes the ability of a health care clinic to submit a surety bond instead of submitting certain documents as proof of financial ability to operate, in order to satisfy initial licensure requirements.
- Creates risked-based licensure inspections for nurse registries, home medical equipment providers, and health care clinics to provide the AHCA flexibility to inspect high-performing providers less frequently than poor performers.
- Authorizes the AHCA to adopt rules to waive a routine inspection, to waive an inspection for relicensure, or to allow an extended period between inspections for any provider type based upon specified factors.
- Authorizes the AHCA to issue a provisional license to all provider types.
- Revises requirements for the approval of comprehensive emergency management plans for newly-licensed facilities.
- Authorizes the AHCA to collect all legal fees incurred while defending a Medicaid case if the AHCA prevails.
- Clarifies the AHCA's existing statutory authority to conduct retrospective reviews of Medicaid hospital inpatient claims and recover overpayments.

- Revises background screening regulations for health care provider staff.
- Eliminates the AHCA's authority to establish an alternative methodology to the DRG-based prospective payment system for setting reimbursement rates for class III psychiatric hospitals.
- Aligns the state Medicaid anti-kickback law with the federal anti-kickback law.
- Requires the AHCA to extend the term of contracts awarded to Statewide Medicaid Managed Care plans (the Managed Medical Assistance Program, Long-term Care Managed Care Program, and Dental Program) from five years to six years, effectively extending current contracts through December 31, 2024.
- Requires the Florida Center for Health Information and Transparency within the AHCA to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels.
- Expands the list of shoppable health care services that qualify for a shared savings incentive for patients to include services with the most significant price variation. Allows cash and cash equivalent incentives in shared savings incentives.
- Repeals multiphasic health testing center licensure.
- Replaces several legislatively mandated reports with online publications and repeals obsolete reports.

If approved by the Governor, the bill takes effect July 1, 2020, except for the provisions to clarify the AHCA's existing authority to conduct retrospective reviews of Medicaid hospital inpatient claims and recover overpayments, which take effect upon the bill becoming a law.

Vote: Senate 38-0; House 100-14

Committee on Health Policy

HB 743 — Nonopioid Alternatives

by Rep. Plakon (SB 1080 by Senators Perry and Baxley)

The bill amends provisions in s. 456.44, F.S., related to the requirement for a health care practitioner to provide a patient with nonopioid alternatives before treating the patient with opioid drugs that are listed as Schedule II controlled substances. The bill provides an exception to the requirement to provide nonopioid alternatives when treating a patient in an emergency room, a critical care unit, or when the patient is receiving hospice services; eliminates the requirement to provide such alternatives when dispensing or administering Schedule II opioids; and allows information on the nonopioid alternatives to be provided to the patient's representative in addition to the patient directly.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 39-0; House 115-0

Committee on Health Policy

CS/CS/HB 763 — Patient Safety Culture Surveys

by Health and Human Services Committee; Health Market Reform Subcommittee; and Rep. Grant, M. and others (CS/CS/SB 1370 by Appropriations Committee; Health Policy Committee; and Senator Harrell)

The bill amends several sections of law to require each hospital and ambulatory surgical center (ASC) to conduct a patient safety culture survey at least biennially. The bill specifies that facilities must use the appropriate hospital or ASC Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality and requires the survey to be anonymous. The bill allows facilities to contract for the administration of the survey and requires each facility to submit survey data to the Agency for Health Care Administration (AHCA).

The bill requires the Florida Center for Health Information and Transparency within the AHCA to customize the survey with additional questions and to collect, compile, and publish aggregated survey data submitted by hospitals and ASCs.

The bill also requires the AHCA to customize the hospital survey to allow respondents to identify themselves as working in certain areas of a facility that are not currently identifiable in the survey, including, a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

The bill appropriates funds from the AHCA's Health Care Trust Fund for the AHCA to hire one full-time equivalent position in Fiscal Year 2020-2021 for the purpose of implementing the bill.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 40-0; House 119-0

Committee on Health Policy

CS/CS/HB 767 — Assisted Living Facilities

by Health and Human Services Committee; Health Market Reform Subcommittee; and Rep. Grant and others (CS/CS/SB 402 by Appropriations Committee; Health Policy Committee; and Senator Harrell)

The bill amends various statutes related to the regulation of an assisted living facility (ALF). The bill:

- Allows the use of certain physical restraints in ALFs, including any device the resident chooses to use and is able to remove or avoid independently.
- Requires ALFs to submit a preliminary adverse incident report and final report through the Agency for Health Care Administration's (AHCA) online portal or by electronic mail if the portal is offline.
- Revises adverse incident reporting notifications for the AHCA and requirements for ALFs.
- Authorizes unlicensed ALF staff to change the bandages of residents for minor cuts and abrasions.
- Authorizes a resident or his or her representative, designee, surrogate, guardian, or attorney, as applicable, to contract for services with a third party and provides requirements for third-party communication with the facility and for an ALF to document that it received such communication.
- Removes the preexisting requirement for ALF staff assisting with the self-administration of medication to read the label of the medication to the resident. Instead, the bill requires staff to, in the presence of the resident, confirm the medication is correct and advise the resident of the medication name and dosage. The bill also allows the resident to sign a waiver to opt-out of being orally advised and provides that the waiver must be immediately updated each time the resident's medications and dosage change.
- Allows ALFs to admit residents that require 24-hour nursing care, residents that are receiving hospice services, or residents who are bedridden that meet specific criteria.
- Clarifies the requirements for a resident to be admitted to and retained in an ALF.
- Requires each resident to have a medical examination performed no longer than 60 days prior to or up to 30 days after admission to the ALF and requires the AHCA to adopt a form in rule that may be used by the health care practitioner performing the medical examination.
- Amends the Resident Bill of Rights to allow the State Long-Term Care Ombudsman Program to provide assistance to a resident who needs to be relocated due to the closure of a facility and requires the notice of relocation to include a statement that the resident may contact the ombudsman.
- Requires an ALF to notify a resident's representative or designee of the need for health care services and assist in making appointments if an underlying condition of dementia or cognitive impairment is determined to exist. If the resident does not have a representative or designee or the ALF cannot reach their representative or designee, the ALF must arrange for the necessary care and services to treat the condition with an appropriate health care provider.

- Amends the AHCA's rulemaking authority to account for technological advances in the provision of care, safety, and security.
- Clarifies who may approve an ALF's comprehensive emergency management plan and allows an ALF to submit the plan up to 30 days after receiving a license.
- Requires the AHCA to conduct a full inspection instead of an abbreviated biennial licensure inspection to review the key quality-of-care standards for a facility that has a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program.
- Consolidates provisions related to fire safety into their own section of law rather than being intermingled with the AHCA's rulemaking authority.
- Amends several provisions related to the ALF administrator core competency curriculum and examination to clarify that the AHCA must adopt an outline and learning objectives for such curriculum.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 39-0; House 119-0

Committee on Health Policy

CS/CS/CS/SB 810 — Tobacco and Nicotine Products

by Appropriations Committee; Innovation, Industry and Technology Committee; Health Policy Committee; and Senators Simmons, Flores, and Mayfield

The bill, consistent with federal law enacted in December 2019, increases the minimum age to lawfully purchase and possess tobacco products from 18 years of age to 21 years of age. The bill also expands the regulations of the retail sale of tobacco products by the Division of Alcoholic Beverages and Tobacco (the division) of the Department of Business and Professional Regulation to include vapor-generating electronic devices and nicotine products.

The bill modifies or adds the following definitions:

- Expands the preexisting definition of "tobacco products" to include "any nicotine product or vapor-generating electronic device."
- Defines "nicotine product" as any product that contains nicotine, including liquid nicotine, which is intended for human consumption, whether inhaled, chewed, absorbed, dissolved, or ingested by any means. The term includes vapor-generating electronic devices.
- Defines "vapor-generating electronic device" as any product that employs an electronic, chemical, or mechanical means capable of producing vapor or aerosol from a nicotine product or any other substance, including, but not limited to, an electronic cigarette, electronic cigar, electronic cigarillo, electronic pipe, or other similar device or product; any replacement cartridge for such device; and any other container of nicotine in a solution or other substance form intended to be used with or within an electronic cigarette, an electronic cigar, an electronic cigarillo, an electronic pipe, a vape pen, an electronic hookah, or other similar device or product. The term includes any component, part, or accessory of the device and also includes any substance intended to be aerosolized or vaporized during the use of the device, whether or not the substance contains nicotine.
- Defines "liquid nicotine product" as a tobacco product in liquid form composed of nicotine and other chemicals or substances, which is sold or offered for sale for use with a vapor-generating electronic device.
- Provides that the terms "vapor-generating electronic device" and "nicotine product" do not include:
    - Tobacco products as defined under preexisting law, i.e. traditional tobacco leaf-based products and cigarette wrappers;
    - Products regulated as a drug or device by the United States Food and Drug Administration under Chapter V of the Federal Food, Drug, and Cosmetic Act; or
    - Foods that contain incidental amounts of nicotine including, but not limited to, tomatoes, potatoes, eggplants, and cauliflower.

The bill modifies and adds the following permitting structure for the retail sale of tobacco products:

- Authorizes the division to issue a limited retail tobacco products dealer permit to an applicant only dealing, at retail, in liquid nicotine products, nicotine products, or vapor-generating electronic devices, or a combination thereof. The bill prohibits the division from assessing an annual permit fee for this limited permit.
- Prohibits a retailer with a limited permit from dealing, at retail, in tobacco products as defined under preexisting law, including loose tobacco leaves, and products made from tobacco leaves, in whole or in part, and cigarette wrappers, which can be used for smoking, sniffing, or chewing.
- Provides that any retailer that pays the annual permit fee for a retail tobacco products dealer permit may deal, at retail, in all tobacco products.

Regarding the retail sale of tobacco products, the bill:

- Prohibits the sale, delivery, bartering, furnishing, or giving, directly or indirectly, of flavored nicotine products to any person, regardless of age. Defines the term "flavored nicotine product" means a liquid nicotine product containing a natural or artificial constituent or additive that causes the liquid or its vapor to have a distinguishable taste or aroma other than tobacco or menthol, including, but not limited to, fruit, chocolate, vanilla, honey, candy, cocoa, a dessert, an alcoholic beverage, an herb or a spice, or any combination thereof. Provides an exception for products if the U.S. Food and Drug Administration issues a marketing order allowing such product to be sold.
- Maintains the preexisting age-verification requirements for tobacco products sold and delivered by mail order, Internet, or other remote sales while prohibiting deliveries to persons younger than 21 years of age. In this context, "tobacco products" means all cigarettes, smoking tobacco, snuff, fine-cut chewing tobacco, cut and granulated tobacco, Cavendish, and plug or twist tobacco."
- Maintains the preexisting exemption that allows a person acting within their scope of his or her lawful employment to possess tobacco products, even if under the age of 21.
- Requires a two-step age verification for sales and deliveries of vapor-generating electronic devices and liquid nicotine products that are not conducted under the direct control or line of sight of the retail dealer.
- Eliminates exemptions allowing underage persons in the military and emancipated minors to possess and purchase tobacco products consistent with federal law.
- Requires age verification before a sale or delivery of tobacco products to a person under 30 years of age, as required by the federal law enacted in December 2019.

Regarding the penalties for violations of tobacco product restrictions, the bill:

- Prohibits smoking or vaping by any person younger than 21 years of age within 1,000 feet of public or private K-12 school property without regard to the time of day, as opposed to preexisting law that prohibits persons under 18 years of age from smoking or vaping in such locations between the hours of 6 a.m. and midnight. Maintains preexisting law regarding penalties for violating this prohibition. Any person issued a citation for the violation is deemed to be charged with a civil infraction punishable by a maximum civil penalty not to exceed $25, or 50 hours of community service and, for persons under

18 years of age, successful completion of a school-approved anti-tobacco or anti-vaping "alternative to suspension" program.

- Provides that the school-approved anti-tobacco education requirement for persons under 18 years of age charged with underage violations relating to vape product purchases and possession, must also include anti-vaping education programs.
- Repeals s. 877.112, F.S., thereby eliminating the general restrictions on the sale or delivery of nicotine dispensing devices and nicotine products to persons under 18 years of age. Many of these provisions are incorporated into the provisions of ch. 569, F.S., as modified by the bill.

If approved by the Governor, these provisions take effect January 1, 2021.
Vote: Senate 27-9; House 99-17

Committee on Health Policy

CS/HB 1179 — Nondiscrimination in Organ Transplants

by Health Market Reform Subcommittee and Rep. Fischer and others (CS/CS/SB 1556 by Appropriations Committee; Banking and Insurance Committee; and Senator Bean)

The bill prohibits discrimination by specified "covered entities" from denying, refusing to allocate, or lowering an individual's priority for organ transplant services, solely on the basis of an individual's developmental or intellectual disability.

Under the bill, "covered entity" includes health care practitioners, health care facilities, and any other entity responsible for potential recipients of anatomical gifts or organ transplants. A covered entity may not do any of the following based solely on an individual's disability:

- Consider an individual ineligible to receive an anatomical gift or a transplant.
- Deny medical or other services related to an organ transplant, including evaluation, surgery, counseling, and post-transplant treatment and services.
- Refuse to refer an individual to an organ procurement organization or a related specialist for evaluation or receipt of an organ transplant.
- Refuse to place an individual on an organ transplant waiting list.
- Place an individual at a lower priority position on an organ transplant waiting list because of the disability.

A covered entity may take an individual's disability into account if, after an evaluation, a physician finds the individual's disability is medically significant enough to cause impact on the receiving an anatomical gift or organ transplant, but only if the covered entity is making treatment or coverage recommendations. If an individual has the necessary support system to assist him or her in complying with post-transplant medical requirements, a covered entity may not consider the individual's inability to independently comply with the post-transplant medical requirements to be medically significant.

Unless a covered entity can demonstrate that modifications to its policies, practices, or procedures for selecting candidates would fundamentally alter the nature of its services, a covered entity must make reasonable modifications when the modifications are necessary to allow an individual with a disability access to services.

If a covered entity violates the bill's provisions, the bill provides that the qualified individual affected by the violation may bring an action for injunctive or other equitable relief.

The bill provides that it may not be construed to require a covered entity to make a referral or recommendation for or perform a medically inappropriate organ transplant.

The bill prohibits health insurers and health maintenance organizations that provide transplant coverage, from denying coverage for an organ transplant based solely on an individual's disability. The bill provides that this restriction may not be construed to require an insurer or

health maintenance organization to provide coverage for an organ transplant that is not medically necessary.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 38-0; House 111-0

Committee on Health Policy

CS/SB 1344 — Intermediate Care Facilities

by Appropriations Committee and Senator Harrell

The bill establishes a new certificate of need (CON) exemption for an intermediate care facility for the developmentally disabled (ICFDD) for use by clients exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses, requiring increased levels of behavioral, medical, and therapeutic oversight.

The bill specifies requirements that an ICFDD must meet in order to obtain the CON exemption, including bed requirements and the types of clients the ICFDD must serve, and establishes additional licensure criteria for an ICFDD that has been granted the CON exemption.

The bill prohibits the Agency for Health Care Administration from granting more than three CON exemptions under the bill and requires any such CON exemptions to terminate 18 months after being issued, unless construction on the project has begun.

The CON exemption provided under the bill sunsets on July 1, 2022, unless saved from repeal by the Legislature.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 30-8; House 79-36

Committee on Health Policy

CS/HB 1373 — Long-term Care

by Health Market Reform Subcommittee and Rep. Webb and others (CS/SB 1544 by Health Policy Committee and Senator Albritton)

The bill amends s. 409.979, F.S., to provide additional clarity for individuals on the Medicaid Long-Term Care Managed Care waitlist regarding the likelihood that he or she will be eligible for services through the program. The bill provides that personnel of an aging resource center will annually rescreen a person on the waitlist only if that person has a high priority score or upon notification of a significant change in circumstances of a person with a low priority score. Preexisting law requires a rescreening to be conducted annually for all such persons or upon notification of a significant change in the person's circumstances, without regard to the person's priority score.

The bill amends s. 430.205, F.S., to allow a community-care-for-the-elderly service provider to dispute a referral from protective investigations of an elderly adult determined to be in need of services or to be the victim of abuse.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 39-0; House 111-0

Committee on Health Policy

CS/HB 1461 — Health Access Dental Licenses

by Health Quality Subcommittee and Rep. Brown (CS/SB 1296 by Health Policy Committee and Senators Berman and Rodriguez)

The bill revives and reenacts three sections of the Florida Statutes relating to the health access dental license program under the Department of Health (DOH), notwithstanding the sunset of those statutes on January 1, 2020.

Under the bill, ss. 466.0067, 466.00671, and 466.00672, F.S., are revived and reenacted to provide for the DOH's authority to issue, renew, and revoke such licenses, respectively. Sections 466.0067 and 466.00671, F.S., are amended only for the purpose of grammatical and stylistic corrections.

The bill provides that the amendments and reenactments contained in the bill are remedial in nature and apply retroactively to January 1, 2020.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 116-0

Committee on Health Policy

CS/SB 1742 — Home Medical Equipment Providers

by Appropriations Committee and Senators Mayfield and Bean

The bill amends s. 400.93, F.S., to exempt physicians licensed under chs. 458, 459, or 460, F.S., from the requirement to be licensed as a home medical equipment provider in order to sell or rent electrostimulation medical equipment and supplies to their own patients in the course of their practice. Medical doctors, osteopathic physicians, and chiropractic physicians are included in the exemption.

If approved by the Governor, these provisions take effect July 1, 2020.
Vote: Senate 40-0; House 116-0