

**The Florida Senate**  
**COMMITTEE MEETING EXPANDED AGENDA**

**HEALTH POLICY**  
**Senator Bean, Chair**  
**Senator Sobel, Vice Chair**

**MEETING DATE:** Tuesday, February 11, 2014  
**TIME:** 2:00 —4:00 p.m.  
**PLACE:** Pat Thomas Committee Room, 412 Knott Building

**MEMBERS:** Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Brandes, Braynon, Flores, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	<b>SB 670</b> Thrasher (Compare H 569)	Nursing Home Litigation; Providing that a nursing home resident who alleges negligence or a violation of residents' rights has a cause of action against the nursing home licensee or its management company and the licensee's direct caregiver employees; providing that a claim for punitive damages may not be brought unless there is a showing of admissible evidence submitted by the parties which provides a reasonable basis for recovery of punitive damages when certain criteria are applied, etc.  HP      02/11/2014 Temporarily Postponed JU RC	Temporarily Postponed
2	<b>SB 350</b> Abruzzo (Identical CS/H 19, Compare CS/H 17, Link CS/S 262)	Public Records/Yellow Dot Critical Motorist Medical Information Program; Providing an exemption from public records requirements for personal identifying information of participants in a yellow dot critical motorist medical information program; providing for future legislative review and repeal of the exemption; providing a statement of public necessity, etc.  TR      01/09/2014 Favorable HP      02/11/2014 Fav/CS GO RC	Fav/CS Yeas 6 Nays 0
3	<b>SB 306</b> Braynon (Identical H 211)	Community Health Workers; Specifying the duties and activities of community health workers; creating the Community Health Worker Task Force within a Florida College System institution or state university, etc.  HP      02/11/2014 Fav/CS ED CA RC	Fav/CS Yeas 5 Nays 0

**COMMITTEE MEETING EXPANDED AGENDA**

Health Policy

Tuesday, February 11, 2014, 2:00 —4:00 p.m.

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TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	<b>SB 674</b> Bean (Similar H 463)	Background Screening; Authorizing the Department of Highway Safety and Motor Vehicles to share reproductions of driver license images with the Department of Health and the Agency for Health Care Administration for specified purposes; requiring simultaneous submission of a photographic image and electronic fingerprints to the Care Provider Background Screening Clearinghouse; requiring an employer to follow certain criminal history check procedures and include specified information regarding referral and registration of an employee for electronic fingerprinting with the clearinghouse, etc.  HP 02/11/2014 Fav/CS TR CJ	Fav/CS Yeas 6 Nays 0
5	<b>SB 702</b> Bean (Similar H 745)	Pharmacy Audits; Enumerating the rights of pharmacies relating to audits of pharmaceutical services which are conducted by certain entities; exempting audits in which fraudulent activity is suspected or which are related to Medicaid claims; establishing a claim for civil damages if the pharmacy's rights are violated, etc.  HP 02/11/2014 Favorable RI JU	Favorable Yeas 7 Nays 0
Consideration of proposed committee bill:			
6	<b>SPB 7028</b>	Telemedicine; Citing this act as the "Florida Telemedicine Act"; creating licensure and registration requirements; providing health insurer and health plan reimbursement requirements for telemedicine; providing requirements for reimbursement of telemedicine services under the Medicaid program, etc.	Temporarily Postponed
Other Related Meeting Documents			

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

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

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

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BILL: SB 670

INTRODUCER: Senator Thrasher

SUBJECT: Nursing Home Litigation

DATE: February 8, 2014

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	<b>Pre-meeting</b>
2.	_____	_____	JU	_____
3.	_____	_____	RC	_____

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**I. Summary:**

SB 670 amends statutory provisions relating to civil causes of action against nursing homes. The bill:

- Limits the class of persons who may be sued for a violation of a nursing home resident's rights to only the nursing home licensee, a management company employed by a nursing home licensee, or a direct caregiver employee without a preliminary evidentiary hearing.
- Requires the court to hold an evidentiary hearing to determine if sufficient evidence or a reasonable basis exists to find that a person or entity other than the nursing home licensee, the management company for the nursing home, or a direct caregiver owed a specific legal duty to the resident, breached that duty, and the breach of that duty is the legal cause of actual loss, injury, damage, or death to the resident.
- Makes certain provisions of law the exclusive remedy against a nursing home licensee management company for a cause of action for the recovery damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of a resident's statutory rights.
- Requires the court to hold an evidentiary hearing before allowing a claim for punitive damages to proceed.
- Prohibits the use of a state or federal survey report of nursing facilities to establish an entitlement to punitive damages.

**II. Present Situation:**

"Nursing Homes and Related Health Care Facilities" is the subject of ch. 400, F.S. Part I of ch. 400, F.S., establishes the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, and the local long-term care ombudsman councils. Part II of ch. 400, F.S., provides for the regulation of nursing homes, and part III of ch. 400, F.S., provides for the regulation of home health agencies.

The Agency for Health Care Administration (AHCA) is charged with the responsibility of developing rules related to the operation of nursing homes. Section 400.022, F.S., specifies the rights and responsibilities of nursing home residents. Section 400.023, F.S., creates a statutory cause of action against nursing homes that violate the statutory rights of residents. The action may be brought in any court to enforce the resident's rights and to recover actual and punitive damages for any violation of a resident's statutory rights or for negligence.<sup>1</sup> Prevailing plaintiffs may be entitled to recover reasonable attorney fees plus costs of the action along with actual and punitive damages.<sup>2</sup>

Sections 400.023-400.0238, F.S., provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of a resident's statutory rights. A claim for punitive damages is not permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages.<sup>3</sup> A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence as defined in s. 400.0237(2), F.S.<sup>4</sup>

In the case of an employer, principal, corporation, or other entity, punitive damages may be imposed for conduct of an employee or agent only for intentional misconduct or gross negligence which is proven by clear and convincing evidence, and if the employer actively and knowingly participated in the conduct, ratified or consented to the conduct, or engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.<sup>5</sup>

### **Named Defendants and Causes of Action in Nursing Home Cases**

Section 400.023, F.S., provides that "any resident whose rights as specified in this part are violated shall have a cause of action." However, the section does not indicate who may be named as a defendant. Current law in ss. 400.023-400.0238, F.S., provides the exclusive remedy for a cause of action for personal injury or death of a nursing home resident or a violation of the resident's rights statute. Current law further provides that s. 400.023, F.S., "does not preclude theories of recovery not arising out of negligence or s. 400.022[, F.S.,] which are available to the resident or to the [Agency for Health Care Administration]."

### **Liability of Employees, Officers, Directors, or Owners**

In *Estate of Canavan v. National Healthcare Corp.*, 889 So. 2d 825 (Fla. 2d DCA 2004), the court considered whether the managing member of a limited liability company could be held personally liable for damages suffered by a resident in a nursing home. The claimant argued the managing member, Friedbauer, could be held liable.

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<sup>1</sup> Sections 400.023 and 400.0237, F.S.

<sup>2</sup> *Id.*

<sup>3</sup> Section 400.0237(1), F.S.

<sup>4</sup> Section 400.0237(2), F.S.

<sup>5</sup> Section 400.0237(3), F.S.

[The claimant] argues that the concept of piercing the corporate veil does not apply in the case of a tort, and that it presented sufficient evidence of Friedbauer's negligence, by act or omission, for the jury to reasonably conclude that Friedbauer caused harm to Canavan. [The claimant] argues that Friedbauer had the responsibility of approving the budget for the nursing home. He also functioned as the sole member of the "governing body" of the nursing home, and pursuant to federal regulation 42 C.F.R. § 483.75(d) 2002, the governing body is legally responsible for establishing and implementing policies regarding the management and operation of the facility and for appointing the administrator who is responsible for the management of the facility. Friedbauer was thus required by federal mandate to create, approve, and implement the facility's policies and procedures. Because he ignored complaints of inadequate staffing while cutting the operating expenses, and because the problems Canavan suffered, pressure sores, infections, poor hygiene, malnutrition and dehydration, were the direct result of understaffing, [The claimant] argues that a reasonable jury could have found that Friedbauer's elevation of profit over patient care was negligent.<sup>6</sup>

The trial court granted a directed verdict in favor of Friedbauer, finding that there was no basis upon which a corporate officer could be held liable. On appeal, the district court reversed:

We conclude that the trial court erred in granting the directed verdict because there was evidence by which the jury could have found that Friedbauer's negligence in ignoring the documented problems at the facility contributed to the harm suffered by Canavan. This was not a case in which the plaintiffs were required to pierce the corporate veil in order to establish individual liability because Friedbauer's alleged negligence constituted tortious conduct, which is not shielded from individual liability. We, therefore, reverse the order granting the directed verdict and remand for a new trial against Friedbauer.<sup>7</sup>

### **Elements in a Civil Action Under s. 400.023, F.S.**

Section 400.023(2), F.S., provides that in any claim alleging a violation of a resident's rights or alleging that negligence caused injury to or the death of a resident, the claimant must prove, by a preponderance of the evidence:

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<sup>6</sup> *Estate of Canavan v. National Healthcare Corp.*, 889 So. 2d 825, 826 (Fla. 2d DCA 1994).

<sup>7</sup> *Estate of Canavan v. National Healthcare Corp.*, 889 So. 2d 825, 826-827 (Fla. 2d DCA 1994)(citations omitted). One author has criticized the *Canavan* decision as "arguably an example of personal liability founded on business decisions normally protected by the 'business judgment rule,' which immunizes directors' business decisions from claims founded on simple negligence." Christopher A. Cazin, *Personal Liability Exposure for Nursing Home Operators: Canavan's Encroachment on the Business Judgment Rule*, 85 FLA. B.J. 46, 46 (May 2011). "Under the [business judgment rule], a company's directors are given liberal discretion to make management and policy decisions, and a court should not substitute its judgment for that of the directors." *Id.* (citing *Lobato-Bleidt v. Lobato*, 668 So. 2d 431, 434 (Fla. 5th DCA 1997)).

- The defendant owed a duty to the resident;
- The defendant breached the duty to the resident;
- The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and
- The resident sustained loss, injury, death, or damage as a result of the breach.

The Florida Supreme Court has set forth the elements of a negligence action:

1. A duty, or obligation, recognized by the law, requiring the [defendant] to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
2. A failure on the [defendant's] part to conform to the standard required: a breach of the duty....
3. A reasonably close causal connection between the conduct and the resulting injury. This is what is commonly known as “legal cause,” or “proximate cause,” and which includes the notion of cause in fact.
4. Actual loss or damage....<sup>8</sup>

Current law provides in any claim brought pursuant to s. 400.023, F.S., a licensee, person, or entity has the duty to exercise “reasonable care” and nurses<sup>9</sup> have the duty to exercise care “consistent with the prevailing professional standard of care.”<sup>10</sup>

### **Punitive Damages**

Current law provides for recovery of punitive damages by a claimant. Punitive damages “are not compensation for injury. Instead, they are private fines levied by civil juries to punish reprehensible conduct and to deter its future occurrence.”<sup>11</sup> Punitive damages are generally limited to three times the amount of compensatory damages or \$1 million, whichever is greater.<sup>12</sup> Damages can exceed \$1 million if the jury finds that the wrongful conduct was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant.<sup>13</sup> If the jury finds that the defendant had a specific intent to harm the claimant and determines that the defendant’s conduct did in fact harm the claimant, there is no cap on punitive damages.<sup>14</sup>

<sup>8</sup> *United States v. Stevens*, 994 So. 2d 1062, 1065-66 (Fla. 2008).

<sup>9</sup> “The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.” s. 400.023(4), F.S.

<sup>10</sup> See s. 400.023(3) and (4), F.S.

<sup>11</sup> *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 350 (1974).

<sup>12</sup> See s. 400.0238(1)(a), F.S.

<sup>13</sup> See s. 400.0238(1)(b), F.S.

<sup>14</sup> See s. 400.0238(1)(c), F.S.

## **Evidentiary Requirements to Bring a Punitive Damages Claim**

Section 400.0237(1), F.S., provides:

In any action for damages brought under this part, no claim for punitive damages shall be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No discovery of financial worth shall proceed until after the pleading concerning punitive damages is permitted.

A court discussed how a claimant can make a proffer to assert a punitive damages claim:

[A] ‘proffer’ according to traditional notions of the term, connotes merely an ‘offer’ of evidence and neither the term standing alone nor the statute itself calls for an adjudication of the underlying veracity of that which is submitted, much less for countervailing evidentiary submissions. Therefore, a proffer is merely a representation of what evidence the defendant proposes to present and is not actual evidence. A reasonable showing by evidence in the record would typically include depositions, interrogatories, and requests for admissions that have been filed with the court. Hence, an evidentiary hearing where witnesses testify and evidence is offered and scrutinized under the pertinent evidentiary rules, as in a trial, is neither contemplated nor mandated by the statute in order to determine whether a reasonable basis has been established to plead punitive damages.<sup>15, 16</sup>

Punitive damages claims are often raised after the initial complaint has been filed. Once a claimant discovers enough evidence that the claimant believes justifies a punitive damages claim, the claimant files a motion to amend the complaint to add a punitive damages action. The trial judge considers the evidence presented and proffered by the claimant to determine whether the claim should proceed.

## **Individual Liability for Punitive Damages**

Section 400.0237(2), F.S., provides:

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<sup>15</sup> *Estate of Despain v. Avante Group, Inc.*, 900 So. 2d 637, 642 (Fla. 5th DCA 2005)(internal citations omitted).

<sup>16</sup> The *Despain* court was discussing a prior version of the punitive damages statute relating to nursing home litigation, but the language on proffering in that statute is the same as that in current law.

A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct<sup>17</sup> or gross negligence.<sup>18</sup>

### **Vicarious Liability for Punitive Damages**

Punitive damages claims are sometimes brought under a theory of vicarious liability where an employer is held responsible for the acts of an employee. Section 400.0273(3), F.S., provides:

In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in subsection (2)<sup>19</sup> and:

- (a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;
- (b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or
- (c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.

### **III. Effect of Proposed Changes:**

**Section 1** amends s. 400.023, F.S., as follows:

#### **Named Defendants in Nursing Home Cases**

The bill provides that any resident who alleges negligence or a violation of nursing home resident's rights has a cause of action against the licensee, the licensee's management company, or the licensee's direct caregiver employees. In effect, the bill limits the persons who may be sued to only the nursing home licensee, the management company for the nursing home licensee, or a direct caregiver employee, without a preliminary evidentiary hearing.

#### **Liability of those Other than a Nursing Home Licensee, a Management Company Employed by the Nursing Home Licensee, or a Direct Caregiver Employee**

The bill places limitations on a cause of action that may be asserted against a person or entity that is not the nursing home licensee, a management company employed by the nursing home licensee, or a direct caregiver employee. As a prerequisite to asserting such actions, after sufficient notice and opportunity to defend, the court must determine there is sufficient evidence in the record or a reasonable basis for the finding that person or entity owed a specific legal duty

<sup>17</sup> "Intentional misconduct" is actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant will result and, despite that knowledge, intentionally pursuing a course of conduct that results in injury or damage. *See* s. 400.0237(2)(a), F.S.

<sup>18</sup> "Gross negligence" is conduct that is so reckless or wanting in care such that it constitutes a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct. *See* s. 400.0237(2)(b), F.S.

<sup>19</sup> Criteria are whether the defendant was personally guilty of intentional misconduct or gross negligence.

to the resident. The court must also find that the duty to that person or entity was breached and that the breach of that duty is the legal cause of actual loss, damage, or death to the resident.

The court must make this finding at an evidentiary hearing after considering evidence in the record and proffered by the claimant.

### **Causes of Action in Nursing Home Cases**

Section 400.023, F.S., states that “any resident whose rights as specified in this part are violated shall have a cause of action.” An aggrieved nursing home resident may sue under the statute,<sup>20</sup> and may sue under other appropriate legal theories. A remedy created by statute may only supplant other statutory and common law remedies if the statute specifically states that it is an exclusive remedy.<sup>21</sup> Section 400.023, F.S., is not an exclusive remedy statute.<sup>22</sup>

The bill amends s. 400.023, F.S., to provide that the provisions of ss. 400.023 – 400.0238, F.S., are the exclusive remedy against a nursing home licensee or management company for a cause of action for recovery of personal injury or death of a nursing home resident arising out of negligence or a violation of a resident’s statutory rights.

**Section 2** amends s. 400.0237, F.S.

### **Evidentiary Requirements to Bring a Punitive Damages Claim**

The bill provides that a claimant may not bring a claim for punitive damages unless admissible evidence submitted by the parties provides a reasonable basis for the recovery of punitive damages. The bill requires the court to conduct an evidentiary hearing where both sides present evidence. The judge must find that a reasonable basis exists to believe that the claimant will be able to demonstrate, by clear and convincing evidence, that the recovery of punitive damages is warranted. These requirements limit a judge to considering only admissible evidence.

Current law does not require a showing of admissibility at this stage of the proceedings or authorize the claimant and defendant to present evidence before a judge authorizes a claim for punitive damages. Current law contemplates that the claimant will proffer evidence and the court, considering the proffer in the light most favorable to the claimant, will determine whether reasonable basis exists to allow the claimant’s punitive damages case to proceed.<sup>23</sup> Under the bill, the claimant may not proceed with discovery on the defendant’s net worth until after the trial judge approves the pleading on punitive damages.

Current law provides that the rules of civil procedure are to be liberally construed to allow the claimant discovery of admissible evidence on the issue of punitive damages. The bill removes that provision from statute. Discovery in civil cases is governed by the Florida Rules of Civil

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<sup>20</sup> Section 400.023, F.S.

<sup>21</sup> *St. Angelo v. Healthcare and Retirement Corp. of America*, 824 So. 2d 997, 999 (Fla. 4th DCA 2002).

<sup>22</sup>“Appellant has sufficiently alleged violations of right which are guaranteed him under section 400.022[, F.S.]. Nothing in the statute precludes this lawsuit or requires appellant to first bring a simple negligence action.” *Id.* at 1000.

<sup>23</sup> See *Estate of Despain*, *supra*, note 16.

Procedure. Because the rules govern discovery, the effect of removing the provision, if any, is not clear.

### **Individual Liability for Punitive Damages**

The bill provides that a defendant, including the licensee or management company against whom punitive damages is sought, may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that “a specific person or corporate defendant actively and knowingly participated in intentional misconduct or engaged in conduct that constitutes gross negligence and contributed to the loss, damages, or injury suffered by the claimant.”

The current standard jury instructions provide for punitive damages if the defendant was “personally guilty of intentional misconduct.”<sup>24</sup> The bill requires that the defendant “actively and knowingly participated in intentional misconduct.”

### **Vicarious Liability for Punitive Damages**

The bill provides that in the case of vicarious liability of an employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an employee or agent unless:

- An identified employee or agent actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant; and,
- An officer, director, or manager of the actual employer corporation or legal entity condoned, ratified, or consented to the specific conduct alleged.

The bill provides that a state or federal survey report of nursing facilities may not be used to establish an entitlement to punitive damages.

### **Effective Date**

The bill takes effect upon becoming a law.

## **IV. Constitutional Issues:**

### **A. Municipality/County Mandates Restrictions:**

None.

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

None.

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<sup>24</sup> Standard Jury Instructions in Civil Cases, 503.1, Punitive Damages - Bifurcated Procedure *available at* [http://www.floridasupremecourt.org/civ\\_jury\\_instructions/instructions.shtml#500](http://www.floridasupremecourt.org/civ_jury_instructions/instructions.shtml#500) (last visited Mar. 9, 2013).

C. Trust Funds Restrictions:

None.

**V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Indeterminate.

C. Government Sector Impact:

None.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 400.023 and 400.0237.

**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.

By Senator Thrasher

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1                                   A bill to be entitled  
2       An act relating to nursing home litigation; amending  
3       s. 400.023, F.S.; providing that a nursing home  
4       resident who alleges negligence or a violation of  
5       residents' rights has a cause of action against the  
6       nursing home licensee or its management company and  
7       the licensee's direct caregiver employees; declaring  
8       that ss. 400.023-400.0238, F.S., provide the exclusive  
9       remedy against a nursing home licensee or its  
10      management company for a cause of action for recovery  
11      of damages arising out of negligence or a violation of  
12      residents' rights; providing that a cause of action  
13      may not be asserted against certain specified persons  
14      or entities; providing exceptions; amending s.  
15      400.0237, F.S.; providing that a claim for punitive  
16      damages may not be brought unless there is a showing  
17      of admissible evidence submitted by the parties which  
18      provides a reasonable basis for recovery of punitive  
19      damages when certain criteria are applied; requiring  
20      the court to conduct a hearing to determine whether  
21      there is sufficient admissible evidence to ensure that  
22      there is a reasonable basis to believe that the  
23      claimant will be able to demonstrate by clear and  
24      convincing evidence that the recovery of punitive  
25      damages is warranted; requiring the trier of fact to  
26      find by clear and convincing evidence that a specific  
27      person or corporate defendant actively and knowingly  
28      participated in intentional misconduct or engaged in  
29      conduct that constituted gross negligence and

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30 contributed to the loss, damages, or injury suffered  
 31 by the claimant before a defendant may be held liable  
 32 for punitive damages; requiring an officer, director,  
 33 or manager of the employer, corporation, or legal  
 34 entity to condone, ratify, or consent to certain  
 35 specified conduct before holding the licensee  
 36 vicariously liable for punitive damages; providing an  
 37 effective date.

38

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

40

41 Section 1. Section 400.023, Florida Statutes, is amended to  
 42 read:

43 400.023 Civil enforcement.—

44 (1) A Any resident who alleges negligence or a violation of  
 45 whose rights as specified under in this part has are violated  
 46 shall have a cause of action against the licensee or its  
 47 management company, as specifically identified in the nursing  
 48 home's application for licensure, and the licensee's direct  
 49 caregiver employees.

50 (a) Sections 400.023-400.0238 provide the exclusive remedy  
 51 against a licensee or its management company for a cause of  
 52 action for the recovery of damages for the personal injury or  
 53 death of a nursing home resident arising out of negligence or a  
 54 violation of residents' rights specified in s. 400.022. The  
 55 action may be brought by the resident or his or her guardian, by  
 56 a person or organization acting on behalf of a resident with the  
 57 consent of the resident or his or her guardian, or by the  
 58 personal representative of the estate of a deceased resident

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59 regardless of the cause of death.

60 (b) If the action alleges a violation of residents' claim  
61 ~~for the resident's~~ rights or ~~for~~ negligence that caused the  
62 death of the resident, the claimant shall ~~be required to~~ elect  
63 ~~either~~ survival damages pursuant to s. 46.021 or wrongful death  
64 damages pursuant to s. 768.21. If the action alleges a violation  
65 of residents' claim ~~for the resident's~~ rights or ~~for~~ negligence  
66 that did not cause the death of the resident, the personal  
67 representative of the estate may recover damages for the  
68 negligence that caused injury to the resident.

69 (c) The action may be brought in any court of competent  
70 jurisdiction to enforce such rights and to recover actual and  
71 punitive damages for the ~~any~~ violation of the rights of a  
72 resident or for negligence.

73 (d) Any resident who prevails in seeking injunctive relief  
74 or ~~a claim for~~ an administrative remedy is entitled to recover  
75 the costs of the action, and a reasonable attorney ~~attorney's~~  
76 fee assessed against the defendant of up to ~~not to exceed~~  
77 \$25,000. Fees shall be awarded solely for the injunctive or  
78 administrative relief and not for any claim or action for  
79 damages whether such claim or action is brought ~~together~~ with a  
80 request for an injunction or administrative relief or as a  
81 separate action, except as provided under s. 768.79 or the  
82 Florida Rules of Civil Procedure. ~~Sections 400.023-400.0238~~  
83 ~~provide the exclusive remedy for a cause of action for recovery~~  
84 ~~of damages for the personal injury or death of a nursing home~~  
85 ~~resident arising out of negligence or a violation of rights~~  
86 ~~specified in s. 400.022.~~

87 (e) This section does not preclude theories of recovery not

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88 arising out of negligence or s. 400.022 which are available to a  
89 resident or to the agency. ~~The provisions of Chapter 766 does de~~  
90 not apply to a any cause of action brought under ss. 400.023-  
91 400.0238.

92 (2) A cause of action may not be asserted against a person  
93 or entity other than those identified in subsection (1) unless,  
94 following an evidentiary hearing at which such person or entity  
95 has been given sufficient notice and an opportunity to defend,  
96 the court determines there is sufficient evidence in the record  
97 or proffered by the claimant to establish a reasonable basis for  
98 finding that:

99 (a) The person or entity owed a specific legal duty to the  
100 resident and the person or entity breached that duty; and

101 (b) The breach of that duty is the legal cause of actual  
102 loss, injury, damage, or death to the resident.

103 (3)~~(2)~~ In a any claim brought pursuant to this part  
104 alleging a violation of residents' ~~resident's~~ rights or  
105 negligence causing injury to or the death of a resident, the  
106 claimant has ~~shall have~~ the burden of proving, by a  
107 preponderance of the evidence, that:

108 (a) The defendant owed a duty to the resident;

109 (b) The defendant breached the duty to the resident;

110 (c) The breach of the duty is a legal cause of loss,  
111 injury, death, or damage to the resident; and

112 (d) The resident sustained loss, injury, death, or damage  
113 as a result of the breach.

114

115 ~~Nothing in~~ This part does not ~~shall be interpreted to create~~  
116 strict liability. A violation of the rights set forth in s.

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117 400.022, ~~or~~ in any other standard or guidelines specified in  
118 this part, or in any applicable administrative standard or  
119 guidelines of this state or a federal regulatory agency is ~~shall~~  
120 ~~be~~ evidence of negligence but is ~~shall~~ not ~~be~~ considered  
121 negligence per se.

122 (4)~~(3)~~ In a ~~any~~ claim brought pursuant to this section, a  
123 licensee, person, or entity has ~~shall have~~ a duty to exercise  
124 reasonable care. Reasonable care is that degree of care which a  
125 reasonably careful licensee, person, or entity would use under  
126 like circumstances.

127 (5)~~(4)~~ In a ~~any~~ claim for a residents' ~~resident's~~ rights  
128 violation or negligence by a nurse licensed under part I of  
129 chapter 464, such nurse has ~~shall have~~ the duty to exercise care  
130 consistent with the prevailing professional standard of care for  
131 a nurse. The prevailing professional standard of care for a  
132 nurse is ~~shall be~~ that level of care, skill, and treatment  
133 which, in light of all relevant surrounding circumstances, is  
134 recognized as acceptable and appropriate by reasonably prudent  
135 similar nurses.

136 (6)~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical  
137 negligence of any physician rendering care or treatment to the  
138 resident except for the administrative services of a medical  
139 director as required under ~~in~~ this part. ~~Nothing in~~ This  
140 subsection does not ~~shall be construed to~~ protect a licensee,  
141 person, or entity from liability for failure to provide a  
142 resident with appropriate observation, assessment, nursing  
143 diagnosis, planning, intervention, and evaluation of care by  
144 nursing staff.

145 (7)~~(6)~~ The resident or the resident's legal representative

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146 shall serve a copy of a ~~any~~ complaint alleging in whole or in  
147 part a violation of any rights specified in this part to the  
148 agency ~~for Health Care Administration~~ at the time of filing the  
149 initial complaint with the clerk of the court for the county in  
150 which the action is pursued. The requirement of providing a copy  
151 of the complaint to the agency does not impair the resident's  
152 legal rights or ability to seek relief for his or her claim.

153 (8) ~~(7)~~ An action under this part for a violation of rights  
154 or negligence recognized herein is not a claim for medical  
155 malpractice, and ~~the provisions of s. 768.21(8)~~ does ~~de~~ not  
156 apply to a claim alleging death of the resident.

157 Section 2. Section 400.0237, Florida Statutes, is amended  
158 to read:

159 400.0237 Punitive damages; pleading; burden of proof.-

160 (1) ~~A In any action for damages brought under this part, no~~  
161 claim for punitive damages may not be brought under this part  
162 ~~shall be permitted~~ unless there is a reasonable showing of  
163 admissible ~~by~~ evidence submitted ~~in the record or proffered~~ by  
164 the parties which provides ~~claimant which would provide~~ a  
165 reasonable basis for recovery of such damages when the criteria  
166 in this section are applied.

167 (a) The claimant may move to amend her or his complaint to  
168 assert a claim for punitive damages as allowed by the rules of  
169 civil procedure in accordance with evidentiary requirements set  
170 forth in this section.

171 (b) The court shall conduct a hearing to determine whether  
172 there is sufficient admissible evidence submitted by the parties  
173 to ensure that there is a reasonable basis to believe that the  
174 claimant, at trial, will be able to demonstrate by clear and

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2014670\_\_

175 convincing evidence that the recovery of such damages is  
176 warranted.

177 (c) A ~~The rules of civil procedure shall be liberally~~  
178 ~~construed so as to allow the claimant discovery of evidence~~  
179 ~~which appears reasonably calculated to lead to admissible~~  
180 ~~evidence on the issue of punitive damages. No discovery of~~  
181 ~~financial worth~~ may not shall proceed until after the pleading  
182 on concerning punitive damages is approved by the court  
183 permitted.

184 (2) A defendant may be held liable for punitive damages  
185 only if the trier of fact, by ~~based on~~ clear and convincing  
186 evidence, finds that a specific person or corporate defendant  
187 actively and knowingly participated in intentional misconduct or  
188 engaged in conduct that constitutes gross negligence and  
189 contributed to the loss, damages, or injury suffered by the  
190 claimant ~~the defendant was personally guilty of intentional~~  
191 ~~misconduct or gross negligence.~~ As used in this section, the  
192 term:

193 (a) "Intentional misconduct" means that the defendant  
194 against whom punitive damages are sought had actual knowledge of  
195 the wrongfulness of the conduct and the high probability that  
196 injury or damage to the claimant would result and, despite that  
197 knowledge, intentionally pursued that course of conduct,  
198 resulting in injury or damage.

199 (b) "Gross negligence" means that the defendant's conduct  
200 was so reckless or wanting in care that it constituted a  
201 conscious disregard or indifference to the life, safety, or  
202 rights of persons exposed to such conduct.

203 (3) In the case of vicarious liability of an employer,

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204 principal, corporation, or other legal entity, punitive damages  
205 may not be imposed for the conduct of an employee or agent  
206 unless only if the conduct of a specifically identified the  
207 employee or agent meets the criteria specified in subsection (2)  
208 and an officer, director, or manager of the actual employer,  
209 corporation, or legal entity condoned, ratified, or consented to  
210 the specific conduct as provided in subsection (2). A state or  
211 federal survey report of nursing facilities may not be used to  
212 establish an entitlement to punitive damages under this section.

213 ~~(a) The employer, principal, corporation, or other legal~~  
214 ~~entity actively and knowingly participated in such conduct;~~

215 ~~(b) The officers, directors, or managers of the employer,~~  
216 ~~principal, corporation, or other legal entity condoned,~~  
217 ~~ratified, or consented to such conduct; or~~

218 ~~(c) The employer, principal, corporation, or other legal~~  
219 ~~entity engaged in conduct that constituted gross negligence and~~  
220 ~~that contributed to the loss, damages, or injury suffered by the~~  
221 ~~claimant.~~

222 (4) The plaintiff shall ~~must~~ establish at trial, by clear  
223 and convincing evidence, its entitlement to an award of punitive  
224 damages. The "greater weight of the evidence" burden of proof  
225 applies to a determination of the amount of damages.

226 (5) This section is remedial in nature and takes ~~shall take~~  
227 effect upon becoming a law.

228 Section 3. This act shall take effect upon becoming a law.



# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**SENATOR JOHN THRASHER**  
6th District

**COMMITTEES:**  
Rules, *Chair*  
Appropriations  
Appropriations Subcommittee on Education  
Appropriations Subcommittee on Health  
and Human Services  
Community Affairs  
Ethics and Elections  
Gaming  
Judiciary  
Regulated Industries

**JOINT COMMITTEE:**  
Joint Legislative Budget Commission

January 31, 2014

## MEMORANDUM

**To:** Senator Aaron Bean, Chairman  
Senate Health Policy Committee

**Fm:** Senator John Thrasher

**Re:** Senate Bill 670 relating to nursing home litigation

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It will be appreciated if you will agenda my Senate Bill 670 for a hearing by the Senate Health Policy Committee at your earliest convenience.

Thank you for your consideration of this request.

**REPLY TO:**

- 113 Nature Walk Parkway, Suite 106, St. Augustine, Florida 32092 (904) 287-4222 FAX: 1-888-263-3475
- 400 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5006

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**DON GAETZ**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore



**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.)

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

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BILL: CS/SB 350

INTRODUCER: Health Policy Committee and Senator Abruzzo

SUBJECT: Public Records/Yellow Dot Critical Motorist Medical Information Program

DATE: February 11, 2014

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Everette	Eichin	TR	<b>Favorable</b>
2.	Peterson	Stovall	HP	<b>Fav/CS</b>
3.			GO	
4.			RC	

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

COMMITTEE SUBSTITUTE - Technical Changes

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**I. Summary:**

CS/SB 350, which is tied to SB 262, creates a public records exemption for personal identifying information of a person who participates in a yellow dot critical motorist medical information program. A yellow dot critical motorist medical information program creates a mechanism for providing medical and emergency contact information to emergency medical responders in the event of a motor vehicle accident or medical emergency. Program participants receive a yellow dot to place on their rear window, which alerts law enforcement or emergency medical responders to look for a yellow folder in the glove box that contains the medical information.

The exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2019, unless reviewed and reenacted by the Legislature.

The bill contains a public necessity statement as required by the Florida Constitution.

Because this bill creates a new public records exemption, a two-thirds vote of the members present and voting in each house of the Legislature is required for passage.

**II. Present Situation:**

The yellow dot critical motorist medical information program is a means to alert first responders at an accident scene to search for information about the injured person—especially if the person

is unable to speak. The program, which began in Connecticut in 2002, has now been adopted in other states, including seven Florida counties.<sup>1</sup>

SB 262 creates specific authorization for counties to implement a program, as follows. After completing an application, the participant will receive a yellow dot decal to place on the vehicle rear window (or clearly visible location on a motorcycle), a yellow dot folder, and a form for the participant's information. The form, which is to be placed inside the folder, includes the following information about the participant:

- Name;
- Photograph;
- Emergency contact information of not more than two people;
- Medical information, including medical conditions, recent surgeries, allergies and medications;
- Preferred hospital; and,
- Contact information for not more than two physicians.

The participant's signature on the form authorizes release of the information for the purposes authorized by the bill. These include: to identify the participant; to determine whether the participant has a medical condition that would impede communication; to access the medical information form; and to ensure that information about current medications and conditions may be considered during emergency medical treatment.

### **Public Records Laws**

The Florida Constitution provides every person the right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.<sup>2</sup> The records of the legislative, executive, and judicial branches are specifically included.<sup>3</sup>

The Florida Statutes also specify conditions under which public access must be provided to government records. The Public Records Act<sup>4</sup> guarantees every person's right to inspect and

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<sup>1</sup> Broward, Miami/Dade, Orange, Osceola, Palm Beach County, Polk, and St. Lucie. My Yellow Dots Program Information Exchange, [http://www.myyellowdots.com/florida\\_yellow\\_dot.php](http://www.myyellowdots.com/florida_yellow_dot.php) (last visited Jan. 30, 2014).

<sup>2</sup> FLA CONST. art. I, s. 24(a).

<sup>3</sup> *Id.*

<sup>4</sup> Chapter 119, F.S.

copy any state or local government public record<sup>5</sup> at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.<sup>6</sup>

Only the Legislature may create an exemption to public records requirements.<sup>7</sup> Such an exemption must be created by general law and must specifically state the public necessity justifying the exemption.<sup>8</sup> Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law. A bill enacting an exemption may not contain other substantive provisions<sup>9</sup> and must pass by a two-thirds vote of the members present and voting in each house of the Legislature.<sup>10</sup>

The Open Government Sunset Review Act (the Act) prescribes a legislative review process for newly created or substantially amended public records or open meetings exemptions.<sup>11</sup> It requires the automatic repeal of such exemption on October 2 of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.<sup>12</sup> The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary to meet such public purpose.

### III. Effect of Proposed Changes:

The bill creates a public records exemption for personal identifying information of a participant in a yellow dot critical motorist medical information program which is held by a county.

The bill provides for repeal of the exemption pursuant to the Open Government Sunset Review Act on October 2, 2019, unless reviewed and reenacted by the Legislature.

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<sup>5</sup> Section 119.011(12), F.S., defines “public records” to mean “all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.” Section 119.011(2), F.S., defines “agency” to mean “any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.” The Public Records Act does not apply to legislative or judicial records (*see Locke v. Hawkes*, 595 So.2d 32 (Fla. 1992)). *But see* s. 11.0431, F.S. (Providing public access to records of the Senate and the House of Representatives, subject to specified exemptions.)

<sup>6</sup> Section 119.07(1)(a), F.S.

<sup>7</sup> FLA. CONST., art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates *confidential and exempt*. A record classified as exempt from public disclosure may be disclosed under certain circumstances (*see WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004), review denied 892 So.2d 1015 (Fla. 2004); *City of Riviera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 2004); and *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991)). If the Legislature designates a record as confidential and exempt from public disclosure, such record may not be released, by the custodian of public records, to anyone other than the persons or entities specifically designated in the statutory exemption (*see Attorney General Opinion 85-62*, August 1, 1985).

<sup>8</sup> FLA. CONST., art. I, s. 24(c).

<sup>9</sup> The bill may, however, contain multiple exemptions that relate to one subject.

<sup>10</sup> FLA. CONST., art. I, s. 24(c).

<sup>11</sup> Section 119.15, F.S. An exemption is substantially amended if the amendment expands the scope of the exemption to include more records or information or to include meetings as well as records (s. 119.15(4)(b), F.S.). The requirements of the Act do not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System (s. 119.15(2), F.S.).

<sup>12</sup> Section 119.15(3), F.S.

The bill provides a public necessity statement, which is required by the Florida Constitution. The bill states the exemption is necessary to protect the privacy and prevent victimization of program participants and to prevent embarrassment, in the event the identity of the participant were to be correlated to his or her medical records and that information disclosed.

The bill takes effect on the same date SB 262 or similar legislation authorizing a yellow dot critical motorist medical information program takes effect, if adopted during the 2014 Session. SB 262 takes effect July 1, 2014.

#### **IV. Constitutional Issues:**

##### **A. Municipality/County Mandates Restrictions:**

None.

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

###### **Vote Requirement**

Section 24(c), Art. I of the Florida Constitution requires a two-thirds vote of the members present and voting in each house of the Legislature for passage of a newly created or expanded public records or public meetings exemption. Because this bill creates a new public records exemption, it requires a two-thirds vote for passage.

###### **Public Necessity Statement**

Section 24(c), Art. I of the Florida Constitution requires a public necessity statement for a newly created or expanded public records or public meetings exemption. This bill creates a new public records exemption; therefore, it includes a public necessity statement.

##### **C. Trust Funds Restrictions:**

None.

#### **V. Fiscal Impact Statement:**

##### **A. Tax/Fee Issues:**

None.

##### **B. Private Sector Impact:**

None.

##### **C. Government Sector Impact:**

None.

**VI. Technical Deficiencies:**

According to the bill sponsor, a participant receives a blank form which he or she populates with the specified information, including the medical information, and places it in the folder in the glove box. However, SB 262 contains language that implies the medical information is transmitted to the county on the application. The county, in turn, sends the participant the yellow dot decal, yellow dot folder, and yellow dot form populated with the medical information provided by the participant. SB 262 may need to be amended to clarify whether medical information is transmitted to the county on the application.<sup>13</sup>

If the medical information is not transmitted, then information that a county would receive as a result of the program would be limited to information needed to distribute the program materials—most likely, participant name and mailing address. The statement of necessity, however, describes the risk that a participant’s identity could be correlated to his or her medical records—disclosure of which could embarrass the participant. SB 262 limits the use of the information to emergency medical responders. Section 401.30, F.S., requires emergency medical personnel to maintain records of emergency calls for inspection by the Department of Health. In addition, the emergency medical personnel must give the hospital a copy of the patient care record for each patient who is transported. Records of emergency calls which contain patient examination or treatment information are confidential and exempt from the public records law and may not be disclosed without the consent of the person to whom they pertain, except for limited purposes described in law, including treatment.<sup>14</sup> Thus, emergency medical responders would be expressly prohibited from disclosing information about the patient’s medical history. It appears the statement of necessity should be amended to remove the language related to disclosure of medical records (lines 40 – 47).

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill creates an unnumbered section of the Florida Statutes.

**IX. Additional Information:**

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

**CS by Health Policy on February 11, 2014:**

The CS removes the reference to “governing body” and corrects the Open Government Sunset Review repeal date to October 2, 2019.

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<sup>13</sup> SB 262 was not referred to the Senate Health Policy Committee.

<sup>14</sup> Section 401.30(4), F.S.

B. Amendments:

None.

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

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332506

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/11/2014	.	
	.	
	.	
	.	

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

**Senate Amendment**

Delete lines 17 - 22

and insert:

is held by a county participating in such program is exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution.

(2) Subsection (1) is subject to the Open Government Sunset Review Act in accordance with s. 119.15, Florida Statutes, and is repealed on October 2, 2019, unless reviewed and saved from

By Senator Abruzzo

25-00278A-14

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1                   A bill to be entitled  
2       An act relating to public records; providing an  
3       exemption from public records requirements for  
4       personal identifying information of participants in a  
5       yellow dot critical motorist medical information  
6       program; providing for future legislative review and  
7       repeal of the exemption; providing a statement of  
8       public necessity; providing a contingent effective  
9       date.

10  
11 Be It Enacted by the Legislature of the State of Florida:

12  
13       Section 1. Public records exemption; participants in a  
14 yellow dot critical motorist medical information program.-

15       (1) Personal identifying information of a participant in a  
16 yellow dot critical motorist medical information program which  
17 is held by the governing body of a county participating in such  
18 program is exempt from s. 119.07(1), Florida Statutes, and s.  
19 24(a), Article I of the State Constitution.

20       (2) Subsection (1) is subject to the Open Government Sunset  
21 Review Act in accordance with s. 119.15, Florida Statutes, and  
22 is repealed on July 1, 2019, unless reviewed and saved from  
23 repeal through reenactment by the Legislature.

24       Section 2. The Legislature finds that it is a public  
25 necessity that the personal identifying information of a  
26 participant in a yellow dot critical motorist medical  
27 information program held by the governing body of a county  
28 participating in such program be made exempt from s. 119.07(1),  
29 Florida Statutes, and s. 24(a), Article I of the State

25-00278A-14

2014350\_\_

30 Constitution. Nevertheless, allowing the governing bodies of  
31 participating counties to distribute yellow dot folders, as well  
32 as allowing emergency medical responders and law enforcement  
33 agents to access the information provided in yellow dot folders,  
34 will ensure the most rapid and effective treatment for victims  
35 of serious traffic accidents. If the personal identifying  
36 information of a participant in such program were not exempt  
37 from disclosure, any person could inspect and copy documentation  
38 that identifies the program participant. Consequently, the  
39 availability of such information to the public would result in  
40 the invasion of the program participant's privacy. If  
41 information regarding the program participant could be  
42 correlated with his or her medical records, it would be possible  
43 for the public to become aware of any diseases or other medical  
44 concerns for which the qualifying patient is being treated by  
45 his or her physician. This knowledge could be used to embarrass  
46 or humiliate a qualifying patient or to discriminate against him  
47 or her. Finally, protecting the personal identifying information  
48 of a participant in such program prevents the identification of  
49 program participants who could be victimized by robbery,  
50 burglary, or illicit drug activities. Accordingly, the  
51 Legislature finds that the harm to a program participant which  
52 could result from the release of personal identifying  
53 information of the participant outweighs any minimal public  
54 benefit that would be derived from disclosure of that  
55 information to the public. Therefore, it is the finding of the  
56 Legislature that such identifying information must be made  
57 confidential and exempt from public disclosure.

58 Section 3. This act shall take effect on the same date that

25-00278A-14

2014350\_\_

59 SB 262 or similar legislation authorizing the governing body of  
60 a county to create a yellow dot critical motorist medical  
61 information program takes effect, if such legislation is adopted  
62 in the same legislative session or an extension thereof and  
63 becomes a law.



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

### COMMITTEES:

Commerce and Tourism, *Vice Chair*  
Environmental Preservation and  
Conservation, *Vice Chair*  
Appropriations Subcommittee on Education  
Appropriations Subcommittee on Finance and Tax  
Communications, Energy, and Public Utilities  
Military Affairs, Space, and Domestic Security

### JOINT COMMITTEE:

Joint Legislative Auditing Committee, *Chair*

**SENATOR JOSEPH ABRUZZO**  
25th District

January 23<sup>rd</sup>, 2014

The Honorable Aaron Bean  
302 Senate Office Building  
404 South Monroe Street  
Tallahassee, FL 32399

Dear Chairman Bean:

I respectfully request that Senate Bill 350 related to public records/motorist safety and the yellow dot program, be placed on the Health Policy committee agenda. This bill exempts personal medical information of the participants' of the Yellow Dot program from public record. This allows the participants to retain privacy regarding their medical information. This legislation is linked with Senate Bill 262.

Thank you for your consideration. Please let me know if I can provide any further information.

Sincerely,

A handwritten signature in cursive script, appearing to read "Joseph Abruzzo".

Joseph Abruzzo

cc: Sandra Stovall Staff Director

### REPLY TO:

- 12300 Forest Hill Boulevard, Suite 200, Wellington, Florida 33414-5785 (561) 791-4774
- 222 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**DON GAETZ**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore



**ENTERED**

**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.)

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

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BILL: CS/SB 306

INTRODUCER: Health Policy Committee and Senator Braynon

SUBJECT: Community Health Workers

DATE: February 11, 2014

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall	HP	<b>Fav/CS</b>
2.			ED	
3.			CA	
4.			RC	

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

COMMITTEE SUBSTITUTE - Technical Changes

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**I. Summary:**

CS/SB 306 directs the Department of Health (DOH) to create the Community Health Worker (CHW) Task Force within a state college or university. The task force consists of 12 members, with representation from the Senate, the House of Representatives, the executive branch, and community health workers.

The task force is charged with developing recommendations for including CHWs in efforts to enroll residents in health care programs or to help residents navigate available health care services, and to be part of the safety net health care delivery team. The task force must also collaborate with other statewide stakeholders, such as universities, to devise a process that leads to the standardization of qualifications and skills of CHWs who are employed in state-supported health care programs.

The report of the task force is due to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2015.

The section of law created by the bill is repealed December 1, 2015.

## II. Present Situation:

### Community Health Workers

Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. Typically they share ethnicity, language, socioeconomic status, and life experiences with the communities they serve. CHWs have been identified by many titles, such as community health advisors, lay health advocates, “promotores(as),” outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.<sup>1</sup>

References in U.S. literature to CHWs begin in the mid-‘60s when attempts to engage CHWs in low-income communities were experimental responses to the persistent problems of the poor and related more to antipoverty strategies than to specific models of intervention for disease prevention and health care. The documented CHW activities evolved in the subsequent years from special projects funded by short-term public and private grants to a period reflecting discussions of standardized training for CHWs to a period where legislation specifically addressing CHWs—their use and certification—passed in a number of states.<sup>2</sup> By the end of 2013, fifteen states and the District of Columbia had enacted laws addressing CHW infrastructure, professional identity, workforce development, or financing.<sup>3</sup>

In 2009, the Agency for Healthcare Research and Quality (AHRQ) conducted a systematic review of the evidence on CHW interventions, outcomes of such interventions, costs and cost-effectiveness of CHW interventions, and characteristics of CHW training. The report concluded that CHWs can serve as a means to improving outcomes for underserved populations for some health conditions. The effectiveness of CHWs in numerous areas, however, requires further research that addresses the methodological limitations of prior studies.<sup>4</sup>

The first federal effort authorizing CHW programs—the Patient Navigator Outreach and Chronic Disease Prevention Act—passed in 2005. The legislation authorized \$25 million in HRSA-administered grants for patient navigator (a type of CHW) programs to coordinate health care services, provide health screening and health insurance information, conduct outreach to

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<sup>1</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, *Community Health Worker National Workforce Study*, iii-iv (March 2007), available at <http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf> (last visited Jan. 23, 2014).

<sup>2</sup> *Id.* at iv.

<sup>3</sup> Centers for Disease Control and Prevention, *A Summary of State Community Health Worker Laws* (July 2013), available at [http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCQQFjAA&url=http%3A%2F%2Fwww.cdc.gov%2Fdhdsdp%2Fpubs%2Fdocs%2FCHW\\_State\\_Laws.pdf&ei=1ThUq-IB7jKsQSzoCICg&usq=AFQjCNEud90XB-Dxd9c95sYOnoOijIAkrA](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCQQFjAA&url=http%3A%2F%2Fwww.cdc.gov%2Fdhdsdp%2Fpubs%2Fdocs%2FCHW_State_Laws.pdf&ei=1ThUq-IB7jKsQSzoCICg&usq=AFQjCNEud90XB-Dxd9c95sYOnoOijIAkrA) (last visited Jan. 23, 2014).

<sup>4</sup> Agency for Healthcare Research and Quality, *Outcomes of Community Health Worker Interventions* (June 2009), available at <http://www.ahrq.gov/research/findings/evidence-based-reports/comhwork-evidence-report.pdf> (last visited Jan. 29, 2014).

medically underserved populations, and perform other duties common to CHWs.<sup>5</sup> This program was reauthorized in 2010 under the Patient Protection and Affordable Care Act.

In 2000, there were an estimated 86,000 CHWs nationwide. Florida had 2,650 paid and 1,556 volunteer CHWs, which ranked Florida fourth in the nation for the most CHWs in the workforce.<sup>6</sup> In 2010, the U.S. Department of Labor included Community Health Workers in the Standard Occupational Classification (SOC).<sup>7</sup>

### **Florida Community Health Worker Coalition**

In October 2010, the DOH received a grant from the Centers for Disease Control to assist cancer coalitions in improving outcomes through policy, environment, or system change. The Cancer Control and Research Advisory Council (CCRAB)—the statewide cancer council—opted to use the funds to develop and promote the work of CHWs in the state. The DOH convened a task force which became the Florida Community Health Worker Coalition (Coalition). The Coalition is a statewide partnership housed within the University of Florida College of Pharmacy dedicated to the support and promotion of the CHW profession.<sup>8</sup> The Coalition has identified six key issues of interest:

- Institute a standard definition of CHW in Florida<sup>9</sup>
- Establish a database of CHWs
- Standardize training and curriculum standards for CHWs
- Pursue passage of legislation that recognizes the efforts of CHWs throughout Florida
- Continue recruiting membership and stakeholder support
- Pursue reimbursement for CHWs through Medicaid and private insurance<sup>10</sup>

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<sup>5</sup> Pub. Law No. 109-18, H.R. 1812, 109<sup>th</sup> Cong. (June 29, 2005).

<sup>6</sup> *Supra* note 1 at 14.

<sup>7</sup> The 2010 SOC system is used by federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. All workers are classified into one of 840 detailed occupations according to their occupational definition.

<sup>8</sup> University of Florida, College of Pharmacy, *Florida Community Health Worker Coalition* <http://floridachwn.pharmacy.ufl.edu/> (last visited Jan. 23, 2014).

<sup>9</sup> The coalition has adopted the following definition: “A CHW is a frontline health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Some activities performed by the CHW include providing information on available resources, providing social support and informal counseling, advocating for individuals and community health needs, and providing services such as first aid and blood pressure screening. They may also collect data to help identify community health needs.” Florida Cancer Coalition Goal III Sub Committee [sic], *Community Health Worker Initiative A Year in Review 2011* (March 2012), available at [http://floridachwn.pharmacy.ufl.edu/files/2012/03/CHW-Year-In-Review-Final\\_3-8-122.pdf](http://floridachwn.pharmacy.ufl.edu/files/2012/03/CHW-Year-In-Review-Final_3-8-122.pdf) (last visited Jan. 29, 2014).

<sup>10</sup> Florida Cancer Coalition Goal III Sub Committee Community Health Worker Initiative A Year in Review 2011, available at <http://floridachwn.pharmacy.ufl.edu/coalition-2/final-product/> (last visited Jan. 23, 2014).

## Medically Underserved in Florida

Medically underserved areas or populations are those areas or populations designated by the Health Resources Services Administration as having too few primary care providers, high infant mortality, high poverty, and/or high elderly population.<sup>11</sup> Medically underserved areas may consist of a whole county or group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. Medically underserved populations may include groups of persons who face economic, cultural, or linguistic barriers to health care.<sup>12</sup> Medically underserved areas and populations are found in every county in Florida.<sup>13</sup>

For the period 2011-12, twenty-one percent of Floridians, or 3,940,700 people, had no form of health insurance.<sup>14</sup> This is the third-highest uninsured rate among all states, tied with New Mexico and surpassed only by Texas and Nevada.<sup>15</sup>

The federal poverty level for the continental U.S. is currently \$23,550 for a family of four; 185 percent of this is \$43,567.50.<sup>16</sup>

## Statutory Creation of Advisory Bodies, Commissions, or Boards

The statutory creation of any collegial body to serve as an adjunct to an executive agency is subject to certain provisions in s. 20.052, F.S. Such a body may only be created when it is found to be necessary and beneficial to the furtherance of a public purpose, and it must be terminated by the Legislature when it no longer fulfills such a purpose. The Legislature and the public must be kept informed of the numbers, purposes, memberships, activities, and expenses of any collegial or advisory bodies.

A committee or task force is defined in statute to mean “an advisory body created without specific statutory enactment for a time not to exceed 1 year or created by specific statutory enactment for a time not to exceed 3 years and appointed to study a problem and recommend a solution or policy alternative with respect to that problem. Its existence terminates upon the completion of its assignment.”<sup>17</sup>

Private citizen members of any advisory body (with exceptions for members of commissions or boards of trustees) may only be appointed by the Governor, the head of the executive agency to

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<sup>11</sup> HRSA, *Find Shortage Areas: MUA/P by State and County*, available at: <http://muafind.hrsa.gov/> (last visited Jan. 23, 2014).

<sup>12</sup> HRSA, *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*, <http://www.hrsa.gov/shortage/> (last visited Jan. 23, 2014).

<sup>13</sup> *Supra* note 11.

<sup>14</sup> Kaiser Family Foundation, *Florida: Health Insurance Coverage of the Total Population*, (2011-2012), available at: <http://kff.org/other/state-indicator/total-population/?state=FL> (last visited Jan. 29, 2014).

<sup>15</sup> Kaiser Family Foundation, *Health Insurance Coverage of the Total Population* (2011), available at: <http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=125&cat=3&sub=39&sortc=6&o=a> (last visited Jan. 29, 2014).

<sup>16</sup> U.S. Department of Health and Human Services, *2013 Poverty Guidelines*, <http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines> (last visited Jan. 23, 2014).

<sup>17</sup> Section 20.03(8), F.S.

which the advisory body is adjunct, the executive director of the agency, or a Cabinet officer. Private citizen members of a commission or a board of trustees may only be appointed by the Governor, must be confirmed by the Senate, and are subject to the dual-office-holding prohibition of Art. II, s. 5(a) of the State Constitution.

Members of agency advisory bodies serve for 4-year staggered terms and are ineligible for any compensation other than travel expenses, unless expressly provided otherwise in the State Constitution. Unless an exemption is specified by law, all meetings are public, and records of minutes and votes must be maintained.

### III. Effect of Proposed Changes:

**Section 1** provides definitions for various terms and describes the duties of CHWs.

This section also directs the DOH to create, and provide administrative support to, a Community Health Worker Task Force within a state college or university. The task force will be comprised of the following 12 members:

- One member of the Senate, appointed by the President of the Senate.
- One member of the House of Representatives, appointed by the Speaker of the House of Representatives.
- One state official, appointed by the Governor.
- Nine culturally and regionally diverse community health workers, appointed by the State Surgeon General, three of whom are recommended by the chair of the Florida Community Health Worker Coalition.
- Three representatives of the coalition, appointed by the chair of the coalition.

The task force is charged with developing recommendations for:

- Including CHWs in the development of proposals for health care or Medicaid reform in the state as part of the outreach efforts for enrolling residents of this state in Medicaid managed care programs or other health care delivery services;
- Including CHWs in providing assistance to residents in navigating the health care system and providing information and guidance regarding preventive health care; and,
- Providing support to community health centers and other safety net providers through the integration of CHWs as part of health care delivery teams.

The task force must also collaborate with other statewide stakeholders, such as universities, to devise a process that leads to the standardization of qualifications and skills of CHWs who are employed in state-supported health care programs.

The members of the task force will elect a chair and a vice chair, meet at least quarterly with a quorum of seven members, and are not entitled to compensation or reimbursement of travel expenses. The task force will submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2015.

The section of law creating the task force is repealed effective December 1, 2015.

**Section 2** provides that the bill will take effect upon becoming a law.

**IV. Constitutional Issues:**

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

**V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Members of the CHW Task Force will be responsible for their own travel expenses.

C. Government Sector Impact:

The DOH analyzed a similar bill last year (CS/SB 894) and determined that the required duties could be performed within existing resources.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill creates an unnumbered section of the Florida Statutes.

**IX. Additional Information:**

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

**CS by Health Policy on February 11, 2014:**

The CS changes the responsibility for appointing the three representatives of the Florida Community Health Worker Coalition to conform to the procedures for appointments set forth in s. 20.052(5)(a), F.S.

- B. **Amendments:**

None.



187860

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/11/2014	.	
	.	
	.	
	.	

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

**Senate Amendment**

Delete lines 105 - 109

and insert:

4. Nine culturally and regionally diverse community health workers appointed by the Surgeon General, three of whom are recommended by the chair of the Florida Community Health Worker Coalition.

By Senator Braynon

36-00363-14

2014306\_\_

1                   A bill to be entitled  
2       An act relating to community health workers; providing  
3       definitions; specifying the duties and activities of  
4       community health workers; creating the Community  
5       Health Worker Task Force within a Florida College  
6       System institution or state university; requiring the  
7       Department of Health to provide administrative support  
8       and services; providing membership and duties of the  
9       task force; requiring the members of the task force to  
10      elect a chair and vice chair; providing that task  
11      force members serve without compensation and are not  
12      entitled to reimbursement for per diem or travel  
13      expenses; requiring that the task force meet at least  
14      quarterly; authorizing the task force members to meet  
15      in person or by teleconference or other electronic  
16      means; specifying the number of members required for a  
17      quorum; requiring the task force to submit a report to  
18      the Governor and the Legislature by a specified date;  
19      providing for future repeal of the task force;  
20      providing an effective date.

21  
22       WHEREAS, Florida continues to experience critical shortages  
23      of providers in primary health care, oral health care, and  
24      behavioral health care, particularly in rural and inner-city  
25      areas, and

26       WHEREAS, there is substantial evidence that comprehensive  
27      coordination of care for individuals who have chronic diseases  
28      and the provision of information regarding preventive care can  
29      improve individual health, create a healthier population, reduce

36-00363-14

2014306\_\_

30 the costs of health care, and increase appropriate access to  
31 health care, and

32 WHEREAS, community health workers have demonstrated success  
33 in increasing access to health care in underserved communities,  
34 providing culturally appropriate education regarding disease  
35 prevention and management, providing translating and  
36 interpreting services for non-English speakers, improving health  
37 outcomes through the coordination of care, increasing individual  
38 health care literacy and advocacy, and organizing to improve the  
39 health care of medically underserved communities while reducing  
40 costs in the state's health care system, and

41 WHEREAS, the Legislature recognizes that community health  
42 workers are important members of the health care delivery system  
43 in this state, and the Florida Community Health Worker Coalition  
44 has begun to explore options that would allow community health  
45 workers to earn a living wage and be part of an integrated  
46 health delivery team, NOW, THEREFORE,

47  
48 Be It Enacted by the Legislature of the State of Florida:

49  
50 Section 1. Community Health Worker Task Force.—

51 (1) As used in this section, the term:

52 (a) "Community health worker" means a front-line health  
53 care worker who is a trusted member or has an unusually close  
54 understanding of the community that he or she serves and who:

55 1. Serves as a liaison, link, or intermediary between the  
56 health care services or social services and the community in  
57 order to facilitate access to health care services and improve  
58 the quality of health care services and the cultural competency

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2014306\_\_

59 of health care providers.

60 2. Performs the following activities in a community  
61 setting:

62 a. Provides information regarding available resources.

63 b. Provides social support.

64 c. Advocates for individuals and their health care needs.

65 d. Provides services, such as first aid and blood pressure  
66 screening.

67 3. Builds individual and community capacity to prevent  
68 disease and promote health by increasing knowledge regarding  
69 wellness, disease prevention, and self-sufficiency among the  
70 members of the community through a range of activities, such as  
71 community outreach, education, and advocacy.

72 4. Collects data to help identify the health care needs in  
73 a medically underserved community by:

74 a. Enhancing the communication skills of members of the  
75 community in order to assist them in effectively communicating  
76 with health care providers.

77 b. Providing culturally and linguistically appropriate  
78 health or nutrition education.

79 c. Advocating for better individual and community health,  
80 including oral health, mental health, and nutritional needs.

81 d. Providing referral services, followup services, and  
82 coordination of care.

83 (b) "Department" means the Department of Health.

84 (c) "Medically underserved community" means a community in  
85 a geographic area that has a shortage of health care  
86 professionals and has a population that includes persons who do  
87 not have public or private health insurance, are unable to pay

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2014306\_\_

88 for health care, and have incomes at or below 185 percent of the  
89 federal poverty level.

90 (d) "Task force" means the Community Health Worker Task  
91 Force established by the department under this section.

92 (2) (a) The department shall establish the Community Health  
93 Worker Task Force within a Florida College System institution or  
94 state university. The department shall provide administrative  
95 support and services to the task force to the extent requested  
96 by the chair of the task force and within available resources of  
97 the department.

98 (b) The task force shall consist of the following 12  
99 members:

100 1. One member of the Senate appointed by the President of  
101 the Senate.

102 2. One member of the House of Representatives appointed by  
103 the Speaker of the House of Representatives.

104 3. One state official appointed by the Governor.

105 4. Six culturally and regionally diverse community health  
106 workers appointed by the State Surgeon General.

107 5. Three representatives of the Florida Community Health  
108 Worker Coalition appointed by the chair of the Florida Community  
109 Health Worker Coalition.

110 (c) The task force shall develop recommendations for:

111 1. Including community health workers in the development of  
112 proposals for health care or Medicaid reform in this state as  
113 part of the outreach efforts for enrolling residents of this  
114 state in Medicaid managed care programs or other health care  
115 delivery services.

116 2. Including community health workers in providing

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2014306\_\_

117 assistance to residents in navigating the health care system and  
118 providing information and guidance regarding preventive health  
119 care.

120 3. Providing support to community health centers and other  
121 "safety net" providers through the integration of community  
122 health workers as part of health care delivery teams.

123 (d) The task force shall also collaborate with the Florida  
124 Community Health Worker Coalition, colleges and universities in  
125 the state, and other organizations and institutions to recommend  
126 a process that leads to the standardization of qualifications  
127 and skills of community health workers who are employed in  
128 state-supported health care programs.

129 (e) The members of the task force shall elect a chair and  
130 vice chair.

131 (f) Members of the task force shall serve without  
132 compensation and are not entitled to reimbursement for per diem  
133 and travel expenses.

134 (g) The task force shall meet at least quarterly and may  
135 meet at other times upon the call of the chair or as determined  
136 by a majority of members. Meetings of the task force may be held  
137 in person or by teleconference or other electronic means.

138 (h) A quorum shall consist of seven members, and the  
139 concurring vote of a majority of the members present is required  
140 for final action.

141 (i) The task force shall submit a report by June 30, 2015,  
142 to the Governor, the President of the Senate, and the Speaker of  
143 the House of Representatives which states the findings,  
144 conclusions, and recommendations of the task force.

145 (3) This section is repealed December 1, 2015.

36-00363-14

2014306\_\_

146

Section 2. This act shall take effect upon becoming a law.



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:  
Regulated Industries, *Vice Chair*  
Appropriations Subcommittee on Criminal and  
Civil Justice  
Appropriations Subcommittee on General  
Government  
Children, Families, and Elder Affairs  
Ethics and Elections  
Gaming  
Health Policy

### SENATOR OSCAR BRAYNON II

*Democratic Whip*  
36th District

January 14, 2014

Senator Aaron Bean, Chair  
Health Policy  
302 Senate Office Building  
404 South Monroe Street  
Tallahassee, FL 32399-1100

Dear Chair Bean:

This letter is to request that **Senate Bill #306**, relating to *Community Health Workers* be placed on the agenda of the next scheduled meeting of the committee.

*SB 306 Specifying the duties and activities of community health workers; creating the Community Health Worker Task Force within a Florida College System institution or state university, etc.*

Thank you for consideration of this request.

Sincerely,

  
Senator Braynon  
District 36

cc. *Sandra Stovall, Staff Director,*  
*Celia Georgiades, Committee Administrative Assistant, Room 530K*

 ENTERED

REPLY TO:

- 606 NW 183rd Street, Miami Gardens, Florida 33169 (305) 654-7150 FAX: (305) 654-7152
- 213 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5036

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

DON GAETZ  
President of the Senate

GARRETT RICHTER  
President Pro Tempore

**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.)

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

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BILL: CS/SB 674

INTRODUCER: Health Policy Committee and Senator Bean

SUBJECT: Background Screening

DATE: February 11, 2014

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	<b>Fav/CS</b>
2.			TR	
3.			CJ	

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

COMMITTEE SUBSTITUTE - Technical Changes

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**I. Summary:**

CS/SB 674 strengthens and facilitates the background screening provisions for persons required by law to undergo criminal background screening.

The bill updates the disqualifying offenses to include additional offenses involving fraudulent activity for persons screened as a part of health care facility licensure and adds offenses involving attempting, soliciting, or conspiring to commit a listed disqualifying offense for any person subject to background screening.

The 3-year waiting period after payment of court-ordered monetary amounts in order to be eligible for an exemption from disqualification for certain felony convictions is eliminated.

Screenings handled through the Care Provider Background Screening Clearinghouse (Clearinghouse) must now be initiated and registered through the Clearinghouse prior to referring the employee or potential employee for fingerprinting. Additionally, certain identifying information of the person to be fingerprinted must be submitted on behalf of all persons to be screened.

The bill provides for the submission of an individual taxpayer identification number if a social security number cannot be obtained and allows health care facilities and employers that are required to conduct background screenings to submit an attestation, rather than an affidavit, that they have complied with the screening requirements.

The statutory placement of the requirement for submission of a photograph taken at the time of fingerprinting is relocated so that it is not a requirement for all screenings but only for those handled through the Clearinghouse.

The Department of Highway Safety and Motor Vehicles (DHSMV) is authorized to provide driver's license photographs to the Department of Health (DOH) and the Agency for Health Care Administration (AHCA) pursuant to an interagency agreement with each agency.

## II. Present Situation:

### Previous Legislation for Background Screening

Florida has one of the largest vulnerable populations in the country with 17.3 percent of the state's population over the age of 65.<sup>1</sup> In addition to the elderly, the state's vulnerable children and disabled adults require special care because they are at an increased risk of abuse.

In 2010, the Legislature substantially amended the requirements and procedures for background screening.<sup>2</sup> Major changes made by the 2010 legislation include:

- No person who is required to be screened may begin work until the screening has been completed.
- All Level 1<sup>3</sup> screenings were increased to Level 2<sup>4</sup> screenings.
- By July 1, 2012, all fingerprints submitted to the Florida Department of Law Enforcement (FDLE) must be submitted electronically.
- Certain personnel that were not being screened were required to begin Level 2 screening.
- The addition of serious crimes that disqualify an individual from employment working with vulnerable populations.
- Authorization for agencies to request the retention of fingerprints by FDLE.
- That an exemption for a disqualifying felony may not be granted until at least 3 years after the completion of all sentencing sanctions for that felony.
- That all exemptions from disqualification may be granted only by the agency head.

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<sup>1</sup> The Older Population: 2010 Census Briefs, U.S. Census Bureau, Issued November 2011, p. 9, available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf> (Last visited Feb. 7, 2014).

<sup>2</sup> Chapter 2010-114, L.O.F.

<sup>3</sup> Section 435.03, F.S. Level 1 screenings are name-based demographic screenings that must include, but are not limited to, employment history checks and statewide criminal correspondence checks through the FDLE. Level 1 screenings may also include local criminal records checks through local law enforcement agencies. A person undergoing a Level 1 screening must not have been found guilty of any of the listed offenses.

<sup>4</sup> Section 435.04, F.S. A Level 2 screening consists of a fingerprint-based search of the FDLE and the Federal Bureau of Investigation databases for state and national criminal arrest records. Any person undergoing a Level 2 screening must not have been found guilty of any of the listed offenses.

## The Care Provider Background Screening Clearinghouse

In 2012, the Legislature created the Clearinghouse. The Clearinghouse establishes a single data source for background screening results of persons required to be screened by law<sup>5</sup> for employment in positions that provide services to children, the elderly, and disabled individuals.<sup>6</sup> The Clearinghouse allows the results of criminal history checks to be shared among specified state agencies, thereby reducing duplicative screenings for individuals requiring screening across multiple state agencies. In addition applicants now have their fingerprints retained for a period of 5 years. The retention of fingerprints allows the FDLE to report any new arrest/registration information to the specified state agencies. In turn, if during that 5-year period the individual is arrested or added to a registry, a notification will be sent to the employing provider.<sup>7</sup>

The Clearinghouse also collects photographs of applicants who are required to obtain Level 2 background checks. The requirement to submit a photograph was added to law during the 2012 Legislative Session. However, instead of being in the Clearinghouse statute of s. 435.12, F.S., the requirement currently exists in the general Level 2 screening standards of s. 435.04(1)(e), F.S.

Employers of individuals subject to screening by a specified agency<sup>8</sup> are required to register with the Clearinghouse and maintain the employment status of all employees with the Clearinghouse for screenings conducted after the date the state agency begins participation in the Clearinghouse. Initial employment status and any change in status must be reported within 10 business days.<sup>9</sup> Currently, there is no requirement that screenings be initiated through the Clearinghouse.

The Clearinghouse is in the process of being implemented by six designated state agencies. Currently, the clearinghouse is active and being used by the AHCA and the Department of Health (DOH).<sup>10</sup>

## Current Background Screening Law

Florida licensure laws require providers licensed by the AHCA to conduct Level 2 criminal background screening for:<sup>11,12</sup>

- The licensee;

---

<sup>5</sup> Certain persons are required to be screened by specified agencies. “Specified agency” is defined in s. 435.02(5), F.S., and includes the Department of Health, the Department of Children and Families, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities.

<sup>6</sup> *Clearinghouse FAQ*, found at: [http://ahca.myflorida.com/MCHQ/Central\\_Services/Background\\_Screening/docs/ClearinghouseFAQ.pdf](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/docs/ClearinghouseFAQ.pdf), (Last visited on Feb. 7, 2014).

<sup>7</sup> *Id.*

<sup>8</sup> *Supra* n. 5

<sup>9</sup> Section 435.12(2), F.S.

<sup>10</sup> See the AHCA Clearinghouse website at:

[http://ahca.myflorida.com/MCHQ/Central\\_Services/Background\\_Screening/BGS\\_results.shtml](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/BGS_results.shtml), (Last visited Feb. 7, 2014).

<sup>11</sup> Section 408.809, F.S.

<sup>12</sup> For a full list of all employees subject to background screening see, *Who is Required to be Screened*, found at: [http://ahca.myflorida.com/MCHQ/Central\\_Services/Background\\_Screening/docs/BGS\\_WhoRequiredToBeScreened.pdf](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/docs/BGS_WhoRequiredToBeScreened.pdf), (Last visited on Feb. 7, 2014).

- Administrators and financial officers;
- Staff of health care providers who offer residential and home care services that provide personal care services or have access to client property, funds or living areas; and
- Any person who is a controlling interest if there is reason to suspect they have committed a disqualifying criminal offense.

Current background screening standards in ch. 435, F.S., and s. 408.809, F.S., the general licensing provisions for health care providers licensed by the AHCA, include various disqualifying offenses pertaining, but not limited to, domestic violence, patient brokering, criminal use of personal identification information, fraudulent use of credit cards, forgery, and possession/sale of illegal drugs.

Some offenses that presently would disqualify an applicant from employment are very similar to certain offenses that presently do not disqualify an applicant from employment. For example, s. 408.809(4)(k), F.S., states that felonious fraudulent use of credit cards, as described in s. 817.61, F.S., is a disqualifying offense. However, using an expired or falsified credit card to obtain goods, as described in s. 817.841, F.S., is not a disqualifying offense.

Designated agencies have the authority to grant exemptions from disqualification.<sup>13</sup> The exemptions enable people who have been convicted of a disqualifying criminal offense to present information as to why they should not be excluded from working with vulnerable individuals. This information includes: specifics of the offense, how long ago the offense occurred, work history, and rehabilitation. Current law states that an applicant who applies for an exemption for a felony offense must have had 3 years elapse since completion of any sentence or have been lawfully released from confinement, supervision, or sanction for the disqualifying felony.<sup>14</sup> The 3-year waiting period would not have started for the failure to fully satisfy even the smallest related sanction, such as any unpaid balance of a fine. The requirement is similar for disqualifying misdemeanors, except that there is no specific time frame mandated after being lawfully released from confinement, supervision, or sanction.<sup>15,16</sup>

### **DHSMV Driver's License Photograph Access**

The DHSMV has the authority to maintain a record of driver license photographs, signature, and other data required for identification and retrieval.<sup>17</sup> The DHSMV also has the authority to share those photographs, through interagency agreements, with specific state agencies<sup>18</sup> to conduct fraud investigations, protective services, and verification of identity.

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<sup>13</sup> Section 435.07, F.S.

<sup>14</sup> *Id.*

<sup>15</sup> The term "sanction" does not currently have a formal definition in ch. 435, F.S. Numerous state agencies are bound by chapter 435, F.S., and the interpretation of the term "sanction" varies widely among the agencies.

<sup>16</sup> SB 1112 Bill Analysis and Economic Impact Statement, Agency for Health Care Administration, at page 4, Mar. 13, 2013 (on file with the Senate Health Policy Committee).

<sup>17</sup> Section 322.142(4), F.S.

<sup>18</sup> Section 322.142(4), F.S., provides that the Department of Highway Safety and Motor Vehicles may provide reproductions of the file or digital record to the Department of Business and Professional Regulation, the Department of State, the Department of Revenue, the Department of Children and Families, the Department of Financial Services, or to district medical examiners.

### III. Effect of Proposed Changes:

CS/SB 674 strengthens and facilitates the background screening provisions for persons required by law to undergo criminal background screening.

**Section 1** amends s. 322.142, F.S., to allow the DHSMV to share a data file that includes a driver licensee's digital image and signature with the DOH and the AHCA pursuant to an interagency agreement with each agency. The images will be used to verify licensed health care practitioners and persons fingerprinted compared with photographs in the Clearinghouse.

**Section 2** amends s. 408.806, F.S., relating to the licensure application process applicable to health care facilities licensed by the AHCA, to authorize the application and statement regarding compliance with background screening provisions to be an attestation rather than submitted under oath or as an affidavit. An affidavit requires signature in front of a judge, clerk, or deputy clerk of a court.<sup>19</sup> The bill also authorizes an individual taxpayer identification number to be submitted on the application if a social security number cannot be obtained.

**Section 3** amends s. 408.809, F.S., to add to the list of crimes which disqualify an applicant subject to a background check from employment with a health care facility. The added crimes include:

- Attempts, solicitation, and conspiracy to commit an offense listed in s. 408.809(4), F.S.;<sup>20</sup>
- Felonies involving the use of false or expired credit cards;<sup>21</sup>
- Fraudulently obtaining goods or services from a health care provider;<sup>22</sup>
- Crimes related to racketeering and the collection of illegal debts;<sup>23</sup> and
- Violating the provisions in the Florida Money Laundering Act.<sup>24</sup>

This section of the bill also authorizes the statement regarding compliance with the background screening provisions to be an attestation rather than submitted as an affidavit.

The bill revises the AHCA's requirement for acceptance of screening results from outside agencies and allows federal retained prints to satisfy rescreening requirements. A technical change is made to update the statute regarding acceptance of screening results since the Clearinghouse is operational for some specified agencies and background screening results are now being retained.

**Section 4** amends s. 413.208, F.S., and **Section 5** repeals an unnumbered section of a 2012 chapter law relating to the effective date for implementation of the background screening requirements for service providers registering with the Division of Vocational Rehabilitation.

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<sup>19</sup> See s. 92.50, F.S.

<sup>20</sup> As detailed in s. 777.04, F.S.

<sup>21</sup> As detailed in s. 817.481, F.S. The crime is a felony if the value of the goods or services obtained in violation of s. 817.481, F.S., is \$300 or more.

<sup>22</sup> As detailed in s. 817.50, F.S.

<sup>23</sup> As detailed in s. 895.03, F.S.

<sup>24</sup> As detailed in s. 896.101, F.S.

**Section 6** amends s. 435.04, F.S., to require vendors who submit fingerprints on behalf of employers to provide the first, middle, and last name, social security number, date of birth, mailing address, sex, and race of an applicant. If an applicant cannot legally obtain a social security number, then an individual taxpayer identification number must be provided instead. This section also adds attempts, solicitation, and conspiracy to commit any offense listed in s. 435.04(2), F.S.,<sup>25</sup> to the list of crimes which disqualify any applicant subject to a Level 2 background check from employment.

The requirement to obtain a photograph of the applicant at the time the fingerprints are submitted is relocated to s. 435.12, F.S., which is limited to specified agencies participating in the Clearinghouse.

**Section 7** amends s. 435.05, F.S., to allow employers that are required to conduct Level 2 background screenings to attest annually or at the time of license renewal to compliance with background screening requirements rather than submit an affidavit of compliance.

**Section 8** amends s. 435.07, F.S., to strike the term “sanction” from s. 435.07, F.S., and revise the conditions an agency head must consider when determining whether to grant an exemption to disqualification from employment. Under the bill, the 3-year waiting period for a felony offense applies to nonmonetary conditions imposed by the court and not to the satisfaction of monetary requirements. However, all court-ordered fees, fines, or other monetary requirements relating to a disqualifying felony or misdemeanor must be paid in full as a condition of eligibility for an exemption from disqualification of employment.

**Section 9** amends s. 435.12, F.S., to require employers of persons subject to background screening by specified agencies<sup>26</sup> to register and initiate all criminal history checks through the Clearinghouse before referring an employee or potential employee for electronic fingerprint submission to the FDLE. The registration submitted must include the employee’s first, middle, and last name, social security number, date of birth, mailing address, sex, and race. If an applicant cannot legally obtain a social security number, then an individual taxpayer identification number must be provided instead.

The bill authorizes the FDLE to forward notification of arrest to the AHCA once FDLE begins participating in the national retained print arrest notification program which is anticipated to occur later this year. Under this program, arrest prints will be searched against retained prints at the FBI and notification of arrests will be forwarded to the FDLE.

This section now requires a photograph to be submitted at the time fingerprints are submitted, which is transferred from s. 435.04, F.S.

**Section 6** provides for an effective date of July 1, 2014.

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<sup>25</sup> As detailed in s. 777.04, F.S.

<sup>26</sup> *Supra* n. 5

**IV. Constitutional Issues:**

## A. Municipality/County Mandates Restrictions:

None.

## B. Public Records/Open Meetings Issues:

None.

## C. Trust Funds Restrictions:

None.

**V. Fiscal Impact Statement:**

## A. Tax/Fee Issues:

None.

## B. Private Sector Impact:

Employers may see an indeterminate fiscal savings by submitting certain documents under attestation rather than as an affidavit and a reduction in costs associated with hiring new employees due to an increased pool of eligible applicants as a result of removing the 3-year waiting period after payment of all court-ordered monetary amounts before an applicant is eligible for exemption from disqualification for employment. The administrative cost associated with submitting certain identifying information for employee fingerprinting may facilitate and offset administrative costs of tracking the status of results.

## C. Government Sector Impact:

None.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 322.142, 408.806, 408.809, 413.208, 435.04, 435.05, 435.07, and 435.12.

This bill repeals Section 7 of Chapter 2012-73, Laws of Florida.

**IX. Additional Information:**

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

**CS by Health Policy on February 11, 2014:**

Modifies the background screening provisions to make use of the national retained print arrest notification program when the FDLE begins participation in the program.

- B. **Amendments:**

None.



378632

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/11/2014	.	
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	.	

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

**Senate Amendment (with title amendment)**

Delete lines 154 - 171

and insert:

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law



378632

12 Enforcement to forward the person's fingerprints to the Federal  
13 Bureau of Investigation for a national criminal history record  
14 check unless the person's fingerprints are enrolled in the  
15 Federal Bureau of Investigation's national retained print arrest  
16 notification program. If the fingerprints of such a person are  
17 not retained by the Department of Law Enforcement under s.  
18 943.05(2)(g) and (h), the person must submit fingerprints  
19 electronically ~~file a complete set of fingerprints with the~~  
20 ~~agency and the agency shall forward the fingerprints to the~~  
21 Department of Law Enforcement for state processing, and the  
22 Department of Law Enforcement shall forward the fingerprints to  
23 the Federal Bureau of Investigation for a national criminal  
24 history record check. The fingerprints shall ~~may~~ be retained by  
25 the Department of Law Enforcement under s. 943.05(2)(g) and (h)  
26 and enrolled in the national retained print arrest notification  
27 program when the Department of Law Enforcement begins  
28 participation in the program. The cost of the state and  
29

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

31 And the title is amended as follows:

32 Delete line 10

33 and insert:

34 F.S.; exempting a person whose fingerprints are  
35 already enrolled in a certain Federal Bureau of  
36 Investigation program from the requirement that such  
37 fingerprints be forwarded to the bureau; requiring  
38 certain persons to submit their fingerprints  
39 electronically; requiring the Department of Law  
40 Enforcement to retain fingerprints when the department



378632

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42

begins participation in a certain program; revising  
requirements for proof of compliance



569918

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/11/2014	.	
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The Committee on Health Policy (Bean) recommended the following:

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

Delete lines 362 - 370

and insert:

2. Retained by the Federal Bureau of Investigation in the national retained print arrest notification program as soon as the Department of Law Enforcement begins participation in such program. Arrest prints will be searched against retained prints at the Federal Bureau of Investigation and notification of arrests will be forwarded to the Florida Department of Law Enforcement and reported to the Agency for Health Care



569918

12 Administration for inclusion in the clearinghouse.

13 3.2. Resubmitted for a Federal Bureau of Investigation  
14 national criminal history check every 5 years until such time as  
15 the fingerprints are retained by the Federal Bureau of  
16 Investigation.

17 4.3. Subject to retention on a 5-year renewal basis with  
18 fees collected at the time of initial submission or resubmission  
19 of fingerprints.

20 5. Submitted with a photograph of the person taken at the  
21 time the fingerprints are submitted.

22 (b) Until such time as the fingerprints are enrolled in the  
23 national retained print arrest notification program ~~retained~~ at  
24 the Federal Bureau of Investigation, an employee with a break in  
25 service of more than 90 days from a position that requires  
26 screening by a specified agency must submit to a national  
27 screening if the person returns to a position that requires  
28 screening by a specified agency.

29 (c) An employer of persons subject to screening by a  
30 specified agency must register with the clearinghouse and  
31 maintain the employment status of all employees within the  
32 clearinghouse. Initial employment status and any changes in  
33 status must be reported within 10 business days.

34  
35 ===== D I R E C T O R Y C L A U S E A M E N D M E N T =====

36 And the directory clause is amended as follows:

37 Delete lines 348 - 350

38 and insert:

39 Section 9. Subsection (2) of section 435.12, Florida  
40 Statutes, is amended to read:



569918

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51

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

And the title is amended as follows:

Delete line 26

and insert:

conditions; amending s. 435.12, F.S.; requiring the  
fingerprints of an employee required to be screened by  
a specified agency and included in the clearinghouse  
also to be retained in the national retained print  
arrest notification program at a specified time;  
requiring

By Senator Bean

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1                                   A bill to be entitled  
2       An act relating to background screening; amending s.  
3       322.142, F.S.; authorizing the Department of Highway  
4       Safety and Motor Vehicles to share reproductions of  
5       driver license images with the Department of Health  
6       and the Agency for Health Care Administration for  
7       specified purposes; amending s. 408.806, F.S.;  
8       revising the requirements for licensure; revising a  
9       provision requiring an affidavit; amending s. 408.809,  
10      F.S.; revising requirements for proof of compliance  
11      with level 2 screening standards; revising  
12      terminology; adding additional disqualifying offenses  
13      to background screening requirements; amending s.  
14      413.208, F.S.; providing applicability for background  
15      screening requirements for certain registrants;  
16      repealing s. 7 of chapter 2012-73, Laws of Florida,  
17      relating to background screening requirements;  
18      amending s. 435.04, F.S.; revising information to be  
19      required for vendors submitting employee fingerprints;  
20      adding an additional disqualifying offense to  
21      background screening requirements; amending s. 435.05,  
22      F.S.; revising a provision requiring the annual  
23      submission of an affidavit; amending s. 435.07, F.S.;  
24      revising criteria for an exemption from  
25      disqualification for an employee under certain  
26      conditions; amending s. 435.12, F.S.; requiring  
27      simultaneous submission of a photographic image and  
28      electronic fingerprints to the Care Provider  
29      Background Screening Clearinghouse; requiring an

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30 employer to follow certain criminal history check  
31 procedures and include specified information regarding  
32 referral and registration of an employee for  
33 electronic fingerprinting with the clearinghouse;  
34 providing an effective date.

35  
36 Be It Enacted by the Legislature of the State of Florida:

37  
38 Section 1. Subsection (4) of section 322.142, Florida  
39 Statutes, is amended to read:

40 322.142 Color photographic or digital imaged licenses.—

41 (4) The department may maintain a film negative or print  
42 file. The department shall maintain a record of the digital  
43 image and signature of the licensees, together with other data  
44 required by the department for identification and retrieval.  
45 Reproductions from the file or digital record are exempt from  
46 the provisions of s. 119.07(1) and may ~~shall~~ be made and issued  
47 only:

48 (a) For departmental administrative purposes;

49 (b) For the issuance of duplicate licenses;

50 (c) In response to law enforcement agency requests;

51 (d) To the Department of Business and Professional  
52 Regulation and the Department of Health pursuant to an  
53 interagency agreement for the purpose of accessing digital  
54 images for reproduction of licenses issued by the Department of  
55 Business and Professional Regulation or the Department of  
56 Health;

57 (e) To the Department of State pursuant to an interagency  
58 agreement to facilitate determinations of eligibility of voter

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59 registration applicants and registered voters in accordance with  
60 ss. 98.045 and 98.075;

61 (f) To the Department of Revenue pursuant to an interagency  
62 agreement for use in establishing paternity and establishing,  
63 modifying, or enforcing support obligations in Title IV-D cases;

64 (g) To the Department of Children and Families pursuant to  
65 an interagency agreement to conduct protective investigations  
66 under part III of chapter 39 and chapter 415;

67 (h) To the Department of Children and Families pursuant to  
68 an interagency agreement specifying the number of employees in  
69 each of that department's regions to be granted access to the  
70 records for use as verification of identity to expedite the  
71 determination of eligibility for public assistance and for use  
72 in public assistance fraud investigations;

73 (i) To the Agency for Health Care Administration pursuant  
74 to an interagency agreement for the purpose of verifying  
75 photographs in the Care Provider Background Screening  
76 Clearinghouse authorized under s. 435.12;

77 (j)~~(i)~~ To the Department of Financial Services pursuant to  
78 an interagency agreement to facilitate the location of owners of  
79 unclaimed property, the validation of unclaimed property claims,  
80 and the identification of fraudulent or false claims;

81 (k)~~(j)~~ To district medical examiners pursuant to an  
82 interagency agreement for the purpose of identifying a deceased  
83 individual, determining cause of death, and notifying next of  
84 kin of any investigations, including autopsies and other  
85 laboratory examinations, authorized in s. 406.11; or

86 (l)~~(k)~~ To the following persons for the purpose of  
87 identifying a person as part of the official work of a court:

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- 88           1. A justice or judge of this state;
- 89           2. An employee of the state courts system who works in a  
90 position that is designated in writing for access by the Chief  
91 Justice of the Supreme Court or a chief judge of a district or  
92 circuit court, or by his or her designee; or
- 93           3. A government employee who performs functions on behalf  
94 of the state courts system in a position that is designated in  
95 writing for access by the Chief Justice or a chief judge, or by  
96 his or her designee.

97           Section 2. Subsections (1) and (8) of section 408.806,  
98 Florida Statutes, are amended to read:

99           408.806 License application process.—

100           (1) An application for licensure must be made to the agency  
101 on forms furnished by the agency, submitted under oath or  
102 attestation, and accompanied by the appropriate fee in order to  
103 be accepted and considered timely. The application must contain  
104 information required by authorizing statutes and applicable  
105 rules and must include:

106           (a) The name, address, and social security number, or  
107 individual taxpayer identification number if a social security  
108 number cannot legally be obtained, of:

- 109           1. The applicant;
- 110           2. The administrator or a similarly titled person who is  
111 responsible for the day-to-day operation of the provider;
- 112           3. The financial officer or similarly titled person who is  
113 responsible for the financial operation of the licensee or  
114 provider; and
- 115           4. Each controlling interest if the applicant or  
116 controlling interest is an individual.

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117 (b) The name, address, and federal employer identification  
118 number or taxpayer identification number of the applicant and  
119 each controlling interest if the applicant or controlling  
120 interest is not an individual.

121 (c) The name by which the provider is to be known.

122 (d) The total number of beds or capacity requested, as  
123 applicable.

124 (e) The name of the person or persons under whose  
125 management or supervision the provider will operate and the name  
126 of the administrator, if required.

127 (f) If the applicant offers continuing care agreements as  
128 defined in chapter 651, proof shall be furnished that the  
129 applicant has obtained a certificate of authority as required  
130 for operation under chapter 651.

131 (g) Other information, including satisfactory inspection  
132 results, that the agency finds necessary to determine the  
133 ability of the applicant to carry out its responsibilities under  
134 this part, authorizing statutes, and applicable rules.

135 (h) An attestation affidavit, under penalty of perjury, as  
136 required in s. 435.05(3), stating compliance with the provisions  
137 of this section and chapter 435.

138 (8) The agency may establish procedures for the electronic  
139 notification and submission of required information, including,  
140 but not limited to:

141 (a) Licensure applications.

142 (b) Required signatures.

143 (c) Payment of fees.

144 (d) Notarization or attestation of applications.

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146 Requirements for electronic submission of any documents required  
147 by this part or authorizing statutes may be established by rule.  
148 As an alternative to sending documents as required by  
149 authorizing statutes, the agency may provide electronic access  
150 to information or documents.

151 Section 3. Subsections (2) and (4) of section 408.809,  
152 Florida Statutes, are amended to read:

153 408.809 Background screening; prohibited offenses.—

154 (2) Every 5 years following his or her licensure,  
155 employment, or entry into a contract in a capacity that under  
156 subsection (1) would require level 2 background screening under  
157 chapter 435, each such person must submit to level 2 background  
158 rescreening as a condition of retaining such license or  
159 continuing in such employment or contractual status. For any  
160 such rescreening, the agency shall request the Department of Law  
161 Enforcement to forward the person's fingerprints to the Federal  
162 Bureau of Investigation for a national criminal history record  
163 check. If the fingerprints of such a person are not retained by  
164 the Department of Law Enforcement under s. 943.05(2)(g), the  
165 person must file a complete set of fingerprints with the agency  
166 and the agency shall forward the fingerprints to the Department  
167 of Law Enforcement for state processing, and the Department of  
168 Law Enforcement shall forward the fingerprints to the Federal  
169 Bureau of Investigation for a national criminal history record  
170 check. The fingerprints may be retained by the Department of Law  
171 Enforcement under s. 943.05(2)(g). The cost of the state and  
172 national criminal history records checks required by level 2  
173 screening may be borne by the licensee or the person  
174 fingerprinted. Until a specified agency is fully implemented ~~the~~

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175 ~~person's background screening results are retained~~ in the  
176 clearinghouse created under s. 435.12, the agency may accept as  
177 satisfying the requirements of this section proof of compliance  
178 with level 2 screening standards submitted within the previous 5  
179 years to meet any provider or professional licensure  
180 requirements of the agency, the Department of Health, the  
181 Department of Elderly Affairs, the Agency for Persons with  
182 Disabilities, the Department of Children and Families ~~Family~~  
183 ~~Services~~, or the Department of Financial Services for an  
184 applicant for a certificate of authority or provisional  
185 certificate of authority to operate a continuing care retirement  
186 community under chapter 651, provided that:

187 (a) The screening standards and disqualifying offenses for  
188 the prior screening are equivalent to those specified in s.  
189 435.04 and this section;

190 (b) The person subject to screening has not had a break in  
191 service from a position that requires level 2 screening for more  
192 than 90 days; and

193 (c) Such proof is accompanied, under penalty of perjury, by  
194 an attestation ~~affidavit~~ of compliance with ~~the provisions of~~  
195 chapter 435 and this section using forms provided by the agency.

196 (4) In addition to the offenses listed in s. 435.04, all  
197 persons required to undergo background screening pursuant to  
198 this part or authorizing statutes must not have an arrest  
199 awaiting final disposition for, must not have been found guilty  
200 of, regardless of adjudication, or entered a plea of nolo  
201 contendere or guilty to, and must not have been adjudicated  
202 delinquent and the record not have been sealed or expunged for  
203 any of the following offenses or any similar offense of another

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204 jurisdiction:

205 (a) Any authorizing statutes, if the offense was a felony.

206 (b) This chapter, if the offense was a felony.

207 (c) Section 409.920, relating to Medicaid provider fraud.

208 (d) Section 409.9201, relating to Medicaid fraud.

209 (e) Section 741.28, relating to domestic violence.

210 (f) Section 777.04, relating to attempts, solicitation, and  
211 conspiracy to commit an offense listed in this subsection.

212 (g)~~(f)~~ Section 817.034, relating to fraudulent acts through  
213 mail, wire, radio, electromagnetic, photoelectronic, or  
214 photooptical systems.

215 (h)~~(g)~~ Section 817.234, relating to false and fraudulent  
216 insurance claims.

217 (i) Section 817.481, relating to obtaining goods by using a  
218 false or expired credit card or other credit device, if the  
219 offense was a felony.

220 (j) Section 817.50, relating to fraudulently obtaining  
221 goods or services from a health care provider.

222 (k)~~(h)~~ Section 817.505, relating to patient brokering.

223 (l)~~(i)~~ Section 817.568, relating to criminal use of  
224 personal identification information.

225 (m)~~(j)~~ Section 817.60, relating to obtaining a credit card  
226 through fraudulent means.

227 (n)~~(k)~~ Section 817.61, relating to fraudulent use of credit  
228 cards, if the offense was a felony.

229 (o)~~(l)~~ Section 831.01, relating to forgery.

230 (p)~~(m)~~ Section 831.02, relating to uttering forged  
231 instruments.

232 (q)~~(n)~~ Section 831.07, relating to forging bank bills,

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233 checks, drafts, or promissory notes.

234 (r)~~(e)~~ Section 831.09, relating to uttering forged bank  
235 bills, checks, drafts, or promissory notes.

236 (s)~~(p)~~ Section 831.30, relating to fraud in obtaining  
237 medicinal drugs.

238 (t)~~(q)~~ Section 831.31, relating to the sale, manufacture,  
239 delivery, or possession with the intent to sell, manufacture, or  
240 deliver any counterfeit controlled substance, if the offense was  
241 a felony.

242 (u) Section 895.03, relating to racketeering and collection  
243 of unlawful debts.

244 (v) Section 896.101, relating to the Florida Money  
245 Laundering Act.

246 Section 4. Subsection (5) is added to section 413.208,  
247 Florida Statutes, to read:

248 413.208 Service providers; quality assurance; fitness for  
249 responsibilities; background screening.—

250 (5) The background screening requirements of this section  
251 apply only to registrations entered into or renewed with the  
252 division after the Care Provider Background Screening  
253 Clearinghouse becomes operational and retains the background  
254 screening results in the clearinghouse under s. 435.12.

255 Section 5. Section 7 of chapter 2012-73, Laws of Florida,  
256 is repealed.

257 Section 6. Paragraph (e) of subsection (1) of section  
258 435.04, Florida Statutes, is amended, present paragraphs (d)  
259 through (yy) of subsection (2) are redesignated as paragraphs  
260 (e) through (zz), respectively, and a new paragraph (d) is added  
261 to that subsection, to read:

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262 435.04 Level 2 screening standards.—

263 (1)

264 (e) Vendors who submit fingerprints on behalf of employers  
265 must:

266 1. Meet the requirements of s. 943.053; and

267 2. Have the ability to communicate electronically with the  
268 state agency accepting screening results from the Department of  
269 Law Enforcement and provide the applicant's full first name,  
270 middle initial, and last name; social security number; date of  
271 birth; mailing address; sex; and race. Individuals, persons,  
272 applicants, and controlling interests that cannot legally obtain  
273 a social security number must provide an individual taxpayer  
274 identification number ~~a photograph of the applicant taken at the~~  
275 ~~time the fingerprints are submitted.~~

276 (2) The security background investigations under this  
277 section must ensure that no persons subject to the provisions of  
278 this section have been arrested for and are awaiting final  
279 disposition of, have been found guilty of, regardless of  
280 adjudication, or entered a plea of nolo contendere or guilty to,  
281 or have been adjudicated delinquent and the record has not been  
282 sealed or expunged for, any offense prohibited under any of the  
283 following provisions of state law or similar law of another  
284 jurisdiction:

285 (d) Section 777.04, relating to attempts, solicitation, and  
286 conspiracy to commit an offense listed in this subsection.

287 Section 7. Subsection (3) of section 435.05, Florida  
288 Statutes, is amended to read:

289 435.05 Requirements for covered employees and employers.—  
290 Except as otherwise provided by law, the following requirements

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291 apply to covered employees and employers:

292 (3) Each employer licensed or registered with an agency  
293 must conduct level 2 background screening and must submit to the  
294 agency annually or at the time of license renewal, under penalty  
295 of perjury, a signed attestation affidavit attesting to  
296 compliance with the provisions of this chapter.

297 Section 8. Subsections (1) and (2) of section 435.07,  
298 Florida Statutes, are amended to read:

299 435.07 Exemptions from disqualification.—Unless otherwise  
300 provided by law, the provisions of this section apply to  
301 exemptions from disqualification for disqualifying offenses  
302 revealed pursuant to background screenings required under this  
303 chapter, regardless of whether those disqualifying offenses are  
304 listed in this chapter or other laws.

305 (1) (a) The head of the appropriate agency may grant to any  
306 employee otherwise disqualified from employment an exemption  
307 from disqualification for:

308 1. (a) Felonies for which at least 3 years have elapsed  
309 since the applicant for the exemption has completed or been  
310 lawfully released from confinement, supervision, or nonmonetary  
311 condition imposed by the court ~~sanction~~ for the disqualifying  
312 felony;

313 2. (b) Misdemeanors prohibited under any of the statutes  
314 cited in this chapter or under similar statutes of other  
315 jurisdictions for which the applicant for the exemption has  
316 completed or been lawfully released from confinement,  
317 supervision, or nonmonetary condition imposed by the court  
318 ~~sanction~~;

319 3. (c) Offenses that were felonies when committed but that

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320 are now misdemeanors and for which the applicant for the  
321 exemption has completed or been lawfully released from  
322 confinement, supervision, or nonmonetary condition imposed by  
323 the court ~~sanction~~; or

324 4.~~(d)~~ Findings of delinquency. For offenses that would be  
325 felonies if committed by an adult and the record has not been  
326 sealed or expunged, the exemption may not be granted until at  
327 least 3 years have elapsed since the applicant for the exemption  
328 has completed or been lawfully released from confinement,  
329 supervision, or nonmonetary condition imposed by the court  
330 ~~sanction~~ for the disqualifying offense.

331 (b) A person applying for an exemption who was ordered to  
332 pay any amount for any fee, fine, fund, lien, civil judgment,  
333 application, costs of prosecution, trust, or restitution as part  
334 of the judgment and sentence for any disqualifying felony or  
335 misdemeanor must have paid the court-ordered amount in full  
336 before being eligible for the exemption.

337  
338 For the purposes of this subsection, the term "felonies" means  
339 both felonies prohibited under any of the statutes cited in this  
340 chapter or under similar statutes of other jurisdictions.

341 (2) Persons employed, or applicants for employment, by  
342 treatment providers who treat adolescents 13 years of age and  
343 older who are disqualified from employment solely because of  
344 crimes under s. 817.563, s. 893.13, or s. 893.147 may be  
345 exempted from disqualification from employment pursuant to this  
346 chapter without application of the waiting period in  
347 subparagraph (1) (a)1 ~~paragraph (1) (a)~~.

348 Section 9. Paragraph (a) of subsection (2) of section

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349 435.12, Florida Statutes, is amended, and paragraph (d) is added  
350 to that subsection, to read:

351 435.12 Care Provider Background Screening Clearinghouse.—

352 (2) (a) To ensure that the information in the clearinghouse  
353 is current, the fingerprints of an employee required to be  
354 screened by a specified agency and included in the clearinghouse  
355 must be:

356 1. Retained by the Department of Law Enforcement pursuant  
357 to s. 943.05(2) (g) and (h) and (3), and the Department of Law  
358 Enforcement must report the results of searching those  
359 fingerprints against state incoming arrest fingerprint  
360 submissions to the Agency for Health Care Administration for  
361 inclusion in the clearinghouse.

362 2. Resubmitted for a Federal Bureau of Investigation  
363 national criminal history check every 5 years until such time as  
364 the fingerprints are retained by the Federal Bureau of  
365 Investigation.

366 3. Subject to retention on a 5-year renewal basis with fees  
367 collected at the time of initial submission or resubmission of  
368 fingerprints.

369 4. Submitted with a photograph of the person taken at the  
370 time the fingerprints are submitted.

371 (d) An employer must register with and initiate all  
372 criminal history checks through the clearinghouse before  
373 referring an employee or potential employee for electronic  
374 fingerprint submission to the Department of Law Enforcement. The  
375 registration must include the employee's full first name, middle  
376 initial, and last name; social security number; date of birth;  
377 mailing address; sex; and race. Individuals, persons,

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378 applicants, and controlling interests that cannot legally obtain  
379 a social security number must provide an individual taxpayer  
380 identification number.

381 Section 10. This act shall take effect July 1, 2014.

**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.)

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

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BILL: SB 702

INTRODUCER: Senators Bean and Sobel

SUBJECT: Pharmacy Audits

DATE: February 7, 2014

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall	HP	<b>Favorable</b>
2.			RI	
3.			JU	

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**I. Summary:**

SB 702 establishes the rights of a pharmacy when it is audited directly or indirectly by a managed care company, insurance company, third-party payor, pharmacy benefit manager, or an entity that represents responsible parties, such as companies or groups that self-insure. The rights created are largely the same as the requirements currently applicable to Medicaid audits of pharmacies. The rights do not apply to audits based on a suspicion of fraud or audits of Medicaid fee-for-service claims. The bill creates a civil cause of action for treble damages for a pharmacy injured by a willful violation of its rights.

**II. Present Situation:**

**Pharmacy Regulation**

Pharmacies and pharmacists are regulated under the Florida Pharmacy Act (the Act) found in ch. 465, F.S.<sup>1</sup> The Board of Pharmacy (the board) is created within the department to adopt rules to implement provisions of the Act and take other actions according to duties conferred on it in the Act.<sup>2</sup>

Several pharmacy types are specified in law and are required to be permitted or registered under the Act:

- Community pharmacy – a location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.
- Institutional pharmacy – a location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medical drugs are compounded,

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<sup>1</sup> Other pharmacy paraprofessionals, including pharmacy interns and pharmacy technicians, are also regulated under the Act.

<sup>2</sup> Section 465.005, F.S.

dispensed, stored, or sold. The Act further classifies institutional pharmacies according to the type of facility or activities with respect to the handling of drugs within the facility.

- Nuclear pharmacy – a location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold, excluding hospitals or the nuclear medicine facilities of such hospitals.
- Internet pharmacy – a location not otherwise permitted under the Act, whether within or outside the state, which uses the internet to communicate with or obtain information from consumers in this state in order to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state.
- Non-resident pharmacy – a location outside this state which ships, mails, or delivers, in any manner, a dispensed drug into this state.
- Special pharmacy – a location where medicinal drugs are compounded, dispensed, stored, or sold if such location is not otherwise defined which provides miscellaneous specialized pharmacy service functions.

Each pharmacy is subject to inspection by the Department of Health and discipline for violations of applicable state or federal law relating to pharmacy. Any pharmacy located outside this state which ships, mails, or delivers, in any manner, a dispensed drug into this state is considered a nonresident pharmacy, and must register with the board as a nonresident pharmacy.<sup>3,4</sup>

### **Pharmacy Audits**

Advances in pharmaceuticals have transformed health care over the last several decades. Many health care problems are prevented, cured, or managed effectively for years through the use of prescription drugs. As a result, national expenditures for retail prescription drugs have grown from \$120.9 billion in 2000 to 263.3 billion in 2012.<sup>5</sup> Health plan sponsors, which include commercial insurers, private employers, and government plans, such as Medicaid and Medicare, spent \$216.5 billion on prescription drugs in 2012 and consumers paid \$46.8 billion out of pocket for prescription drugs that year.<sup>6</sup>

As expenditures for drugs have increased, health plan sponsors have looked for ways to control that spending. Among other things, they have turned to pharmacy benefit managers (PBMs), which are third party administrators of prescription drug programs. PBMs initially emerged in the 1980s as prescription drug claims processors. PBMs now provide a range of services including developing and managing pharmacy networks, developing drug formularies, providing mail order services, and processing and auditing claims.

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<sup>3</sup> Section 465.0156, F.S.

<sup>4</sup> However, the board may grant an exemption from the registration requirements to any nonresident pharmacy which confines its dispensing activity to isolated transactions. *See* s. 465.0156(2), F.S.

<sup>5</sup> Centers for Medicare and Medicaid Services, *National Health Expenditures Web Tables, Table 16, Retail Prescription Drugs Aggregate, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2012*, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf> (last visited Feb. 6, 2014).

<sup>6</sup> *Id.*

In 2007, there were approximately 70 PBMs operating in the United States and managing prescription drug benefits for an estimated 95 percent of health beneficiaries nationwide.<sup>7</sup> Industry mergers in recent years have cut the number of large PBMs to two which together control 60 percent of the market and provide benefits for approximately 240 million people.<sup>8</sup>

The audit process is one means used by PBMs and health plan sponsors to review pharmacy programs. The audits are designed to ensure that procedures and reimbursement mechanisms are consistent with contractual and regulatory requirements. Over the years, different types of audits have been developed to address changes in benefit and billing processes. A concurrent daily review audit is intended to make immediate changes to a claim before payment is made and is triggered when a PBM or health plan sponsor's computer systems identify an unusual prescription, e.g. by volume dispensed, number of days supplied. A retrospective audit may be conducted as a desk top audit or an in-pharmacy audit. PBM or health plan sponsor staff conduct a desk audit remotely by contacting pharmacies to obtain supporting documentation, such as the written prescription, for a claim the staff are reviewing. An in-pharmacy audit is the most extensive and can last for days or weeks. During an in-pharmacy audit, audit staff require pharmacies to provide documentation for prescriptions dispensed during a specified time period. When the auditors identify errors or lack of documentation to support the claim, they notify the pharmacy and request repayment of all or a portion of the prescription cost. The last form of audit is an investigative audit which occurs where there is a suspicion of fraud or abuse.

Pharmacies have increasingly complained about the onerous and burdensome nature of these audits. A 2011 survey conducted among members of the National Community Pharmacists Association found that pharmacy audits were focusing on trivial errors (misspelling patient names or incorrect data) rather than intentional, fraudulent acts.<sup>9</sup>

Organizations such as the National Community Pharmacists Association,<sup>10</sup> which represents independent pharmacies, have been advocating for legislation at the federal and state levels to address what they perceive as predatory practices by pharmacy benefit managers. As of 2013, 29 states<sup>11</sup> have passed fair and uniform pharmacy audit laws that regulate PBM pharmacy audit practices. Elements of these laws typically include:

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<sup>7</sup> Office of Program Policy Analysis & Government Accountability, *Legislature Could Consider Options to Address Pharmacy Benefit Manager Business Practices*, Report No. 07-08 (Feb. 2007), available at <http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0708rpt.pdf> (last visited Feb. 6, 2014).

<sup>8</sup> Office of Program Policy Analysis & Government Accountability, *Research memorandum: Pharmacy Benefit Managers* (December 2, 2013) (on file with the Senate Health Policy Committee).

<sup>9</sup> National Community Pharmacists Association, *New Survey Reveals Pharmacists are Increasingly Struggling to Care for Patients Amid Predatory Audits, Unfair Reimbursement Practices*, <http://www.ncpanet.org/index.php/news-releases/1062-new-survey-reveals-pharmacists-are-increasingly-struggling-to-care-for-patients-amid-predatory-audits-unfair-reimbursement-practices> (last visited Feb. 6, 2014).

<sup>10</sup> National Community Pharmacists Association, *NCPA to Medicare: Rein in Egregious Pharmacy Audits; Reform Preferred Networks; and Curb Mail Order Waste in 2014 Prescription Drug Plans*. Found at: <http://www.ncpanet.org/index.php/news-releases/1593-ncpa-to-medicare-rein-in-egregious-pharmacy-audits-reform-preferred-networks-and-curb-mail-order-waste-in-2014-prescription-drug-plans> (last visited Feb. 6, 2014).

<sup>11</sup> Alabama, Arizona, California, Colorado, Florida (Medicaid, only), Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, and Vermont.

- Prior notification.
- Limiting the audit timeframe to not more than 24 months.
- Recoupment based on direct evidence and not extrapolation.
- Prohibiting recoupment or penalties for clerical errors.
- Requiring the availability of a consulting pharmacist if the audit involves clinical judgment.
- Providing a timeframe for receiving results and the opportunity to appeal.
- Exempting audits based on a suspicion of fraud from the auditing criteria.<sup>12</sup>

### **Medicaid Pharmacy Audits**

In 2003, the Legislature established requirements for Medicaid audits of pharmacies. The requirements are as follows:

- The agency conducting the audit must give the pharmacist at least one week's prior notice of the initial audit for each audit cycle.
- An audit must be conducted by a pharmacist licensed in Florida.
- Any clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error regarding a document or record required under the Medicaid program does not constitute a willful violation and is not subject to criminal penalties without proof of intent to commit fraud.
- A pharmacist may use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
- A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Each pharmacy shall be audited under the same standards and parameters.
- A pharmacist must be allowed at least 10 days in which to produce documentation to address any discrepancy found during an audit.
- The period covered by an audit may not exceed one calendar year.
- An audit may not be scheduled during the first 5 days of any month due to the high volume of prescriptions filled during that time.
- The audit report must be delivered to the pharmacist within 90 days after conclusion of the audit. A final audit report must be delivered to the pharmacist within 6 months after receipt of the preliminary audit report or final appeal, whichever is later.
- The agency conducting the audit may not use the accounting practice of extrapolation in calculating penalties for Medicaid audits.<sup>13</sup>

The law requires the Agency for Health Care Administration (AHCA) to establish a process that allows a pharmacist to obtain a preliminary review of an audit report and the ability to appeal an unfavorable audit report without the necessity of obtaining legal counsel. The preliminary review and appeal may be conducted by an ad hoc peer review panel, appointed by the AHCA, which consists of pharmacists who maintain an active practice. If, following the preliminary review, the

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<sup>12</sup> Office of Program Policy Analysis & Government Accountability, *supra* note 8.

<sup>13</sup> Section 465.188, F.S.

AHCA or the review panel finds that an unfavorable audit report is unsubstantiated, the AHCA must dismiss the audit report without the necessity of any further proceedings.

These requirements do not apply to investigative audits conducted by the Medicaid Fraud Control Unit of the Department of Legal Affairs or to investigative audits conducted by the AHCA when there is reliable evidence that the claim which is the subject of the audit involves fraud, willful misrepresentation, or abuse under the Medicaid program.

### III. Effect of Proposed Changes:

**Section 1** establishes the rights of a pharmacy when it is audited directly or indirectly by a managed care company, insurance company, third-party payor, pharmacy benefit manager, or an entity that represents responsible parties such as companies or groups, referred to in the bill as “entity.” The rights include:

- To have at least 7 days prior notice of each initial on-site audit;
- To have an on-site audit scheduled during the first 5 days of the month, only by consent of the pharmacist;
- To limit the audit period to 24 months after the date a claim is submitted to or adjudicated by the entity;
- To have an audit that requires clinical or professional judgment conducted by or in consultation with a pharmacist;
- To use the records of a hospital, physician, or other authorized practitioner to validate the pharmacy records;
- To be reimbursed for a claim that was retroactively denied for a clerical, typographical, scrivener’s, or computer error, if the prescription was properly dispensed, unless the pharmacy has a pattern of such errors or fraudulent billing is alleged;
- To receive the preliminary audit report within 90 days after the audit is concluded and the final audit report within 6 months after receiving the preliminary report;
- To have 10 days after the preliminary audit report is delivered in which to produce documentation to address a discrepancy or audit finding; and,
- To have recoupment or penalties based on actual overpayments, not extrapolation.<sup>14</sup>

The rights do not apply to audits that are based on a suspicion of fraud or audits for Medicaid fee-for-service claims. The bill creates a civil cause of action for treble damages for a pharmacy injured by a willful violation of its rights.

**Section 2** provides an effective date of July 1, 2014.

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<sup>14</sup> Extrapolation is a process whereby statistical sampling is used to calculate and project the amount of overpayment made on claims.

**IV. Constitutional Issues:**

## A. Municipality/County Mandates Restrictions:

None.

## B. Public Records/Open Meetings Issues:

None.

## C. Trust Funds Restrictions:

None.

**V. Fiscal Impact Statement:**

## A. Tax/Fee Issues:

None.

## B. Private Sector Impact:

SB 702 will have an indeterminate fiscal impact on the private health sponsors through potential modifications in pharmacy auditing methodologies and limitations on recoupment of claims.

The prior notification requirement and limitation on audits during the first 5 days of the month may allow pharmacies to manage workload more efficiently.

## C. Government Sector Impact:

SB 702 will have an indeterminate, but likely insignificant, fiscal impact on government pharmacies, e.g. public health departments. These pharmacies may file claims from time-to-time with private health sponsors and are subject to random audits, but the substantial majority of their claims are paid by Medicaid.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill creates section 465.1885 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.

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

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By Senator Bean

4-01182-14

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1                   A bill to be entitled  
2           An act relating to pharmacy audits; creating s.  
3           465.1885, F.S.; enumerating the rights of pharmacies  
4           relating to audits of pharmaceutical services which  
5           are conducted by certain entities; exempting audits in  
6           which fraudulent activity is suspected or which are  
7           related to Medicaid claims; establishing a claim for  
8           civil damages if the pharmacy's rights are violated;  
9           providing an effective date.

10  
11 Be It Enacted by the Legislature of the State of Florida:

12  
13           Section 1. Section 465.1885, Florida Statutes, is created  
14 to read:

15           465.1885 Pharmacy audits; rights.-

16           (1) If an audit of the records of a pharmacy licensed under  
17 this chapter is conducted directly or indirectly by a managed  
18 care company, an insurance company, a third-party payor, a  
19 pharmacy benefit manager, or an entity that represents  
20 responsible parties such as companies or groups, referred to as  
21 an "entity" in this section, the pharmacy has the following  
22 rights:

23           (a) To be notified at least 7 calendar days before the  
24 initial on-site audit for each audit cycle.

25           (b) To have the on-site audit scheduled after the first 5  
26 calendar days of a month unless the pharmacist consents  
27 otherwise.

28           (c) To have the audit period limited to 24 months after the  
29 date a claim is submitted to or adjudicated by the entity.

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30 (d) To have an audit that requires clinical or professional  
31 judgment conducted by or in consultation with a pharmacist.

32 (e) To use the records of a hospital, physician, or other  
33 authorized practitioner, which are transmitted by any means of  
34 communication, to validate the pharmacy records.

35 (f) To be reimbursed for a claim that was retroactively  
36 denied for a clerical error, typographical error, scrivener's  
37 error, or computer error if the prescription was properly and  
38 correctly dispensed, unless a pattern of such errors exists or  
39 fraudulent billing is alleged.

40 (g) To receive the preliminary audit report within 90 days  
41 after the conclusion of the audit.

42 (h) To produce documentation to address a discrepancy or  
43 audit finding within 10 business days after the preliminary  
44 audit report is delivered to the pharmacy.

45 (i) To receive the final audit report within 6 months after  
46 receiving the preliminary audit report.

47 (j) To have recoupment or penalties based on actual  
48 overpayments and not according to the accounting practice of  
49 extrapolation.

50 (2) The rights contained in this section do not apply to  
51 audits in which fraudulent activity is suspected or to audits  
52 related to fee-for-service claims under the Medicaid program.

53 (3) A pharmacy injured as a result of a willful violation  
54 of this section shall have a civil cause of action for treble  
55 damages, reasonable attorney fees, and costs.

56 Section 2. This act shall take effect July 1, 2014.

February 10, 2014

The Honorable Aaron Bean  
Chair, Senate Health Policy Committee  
302 Senate Office Building  
404 South Monroe Street  
Tallahassee, FL 32399-1100

**RE: National Community Pharmacists Association Support of S.B.702 – Pharmacy Audits.**

Dear Senator Bean:

I am writing today on behalf of the National Community Pharmacists Association (NCPA) to voice NCPA's sincere appreciation regarding your sponsorship of *S.B.702 – Pharmacy Audits* and to voice NCPA's strong support for S.B.702. This legislation proposes to provide some fair and common sense protections for the community pharmacies of Florida against abusive pharmacy audit practices. We respectfully request all members of the Senate Health Policy Committee to support this much needed legislation and favorably advance it out of committee at their earliest convenience.

NCPA represents America's independent community pharmacists, including the owners of more than 23,000 community pharmacies, pharmacy franchises and chains. Together, they employ over 300,000 full-time employees and dispense nearly half of the nation's retail prescription medicines. In Florida alone there are over 1,300 community pharmacies which employ an estimated 13,000 residents. These pharmacists represent a vital component for both Florida's "Main Street Economy" and its healthcare delivery system.

NCPA has long championed the need for greater oversight of pharmacy benefit managers (PBMs) and many of their questionable business practices due to the problems our members and their patients encounter. PBMs have been allowed to operate virtually unchecked—slowed only by the increasing amount of litigation alleging fraudulent and deceptive business practices filed against the PBMs each year and some extremely limited regulation. One of the largest problems that NCPA pharmacist members face in today's pharmacy marketplace, is the issue of abusive audit practices.

Many PBMs are direct competitors to independent community pharmacies through their own mail order or retail interests, and rather than legitimately using the audit process to guard and protect against fraud, many PBMs now view the pharmacy audit process as a profitable revenue stream for their company at the expense of the competition. These audits can claim thousands of dollars for nothing more than basic administrative or typographical mistakes, many of which were not the error of the pharmacist or pharmacy staff. In many cases, if a PBM auditor identifies an administrative error, he or she will "take back" 100% of the value of the prescription and all refills—a severe financial penalty that is out of proportion with the gravity of the occurrence. Nothing in the legislation before the committee today would prevent audits from occurring for their intended purpose of identifying fraudulent behavior. S.B.702 simply sets reasonable guidelines over the audit practice.

State legislatures nationwide have shown an increased interest in protecting their small business owners from the abusive practices of pharmacy audits. Twenty-nine states have now taken steps to protect pharmacist small business owners against these practices. The state of Virginia recently advanced fair audit legislation out of the state house with a vote of 96-0. NCPA respectfully requests that Florida join this list. Additionally, the Centers for Medicare and Medicaid Services (CMS) has voiced their concern over how PBM auditors are targeting administrative and typographical mistakes where no fraud or financial harm is present in the Part D Program and how PBMs are using these honest mistakes as a profit-making scheme.

NCPA urges committee members to support S.B.702—legislation that will take steps to ensure that if the right patient receives the right dosage of the right prescription on the right date, as prescribed by a doctor, the pharmacy will not be financially penalized through an overaggressive and far reaching PBM audit. Community pharmacists understand that audits are a cost of doing business and necessary to identify those instances where true fraud occurs and are ready to do their part to eliminate fraud in the system. NCPA is confident that once committee members review S.B.702 they will find it simply sets reasonable standards to ensure that audits continue to be useful for their true intent, yet cannot be utilized to only increase PBMs profit margins. If you have any questions about the information contained in this letter or wish to discuss in greater detail, please do not hesitate to contact me at [matt.diloreto@ncpanet.org](mailto:matt.diloreto@ncpanet.org) or at (703) 600-1223.

Sincerely,



Matthew J. DiLoreto

Senior Director, State Government Affairs

*Cc: Members of the Senate Health Policy Committee*



# Florida Pharmacy Association

Supporting Florida Pharmacy Since 1887

Senate Health Policy Committee  
Senator Aaron Bean, Chair  
404 S. Monroe Street  
Tallahassee, FL 32399-1100

Re: Comments on SB702 (Pharmacy Audits)

Dear Members of the Senate Health Policy Committee:

The Florida Pharmacy Association would like to thank you for the opportunity to share the perspectives of Florida pharmacists with regard to SB702 related to pharmacy audits. We find that while many of the health care issues which are discussed within the legislature this one issue on pharmacy audits has universally affected nearly all community pharmacy provider businesses within our industry. Over 90% of prescription benefits delivered through pharmacies are paid for by a third party program through a pharmacy benefits manager. Auditing of pharmacy providers is a way to verify that those services provided and paid for by the plans are documented and actually performed.

## **What is a Pharmacy Benefits Manager**

Pharmacy Benefit Managers (PBMs) contract with employers and managed care companies to coordinate payments for prescription medications as part of a health care benefit package for patients. When they pay for prescriptions, employees present a "pharmacy benefit card" to their pharmacist and make an out-of-pocket co-payment. PBMs act as fiscal intermediaries and enter into contracts with two groups -- employers or insurance companies, on the one hand, and pharmacies on the other hand.

As part of the PBM's oversight of its pharmacy networks an audit of records to ensure compliance and integrity with contractual agreements are necessary and to identify possible fraudulent acts. Audits are performed to ensure that the billing of prescription services is consistent with actual services provided by the pharmacy. This includes validating prescription drug claims data transmitted by the pharmacy to the PBM and matching it with the pharmacy's patient record system. Such records may be paper or electronic.

*Some of the audits where the pharmacy must repay for claims filed have been due to simple clerical errors in record keeping and have nothing to do with fraud or abuse.*

Audits that have resulted in minor differences between claims data and pharmacy records have resulted in business destructive recoupments of pharmacy assets. The recoupment of these dollars has been extracted from payment of other legitimate claims due to the pharmacy.

## Good Public Policy Options for PBM Auditors:

- Clerical errors should not be classified as fraud;
- Pharmacies should receive notice of the audit;
- Prescriber records should be allowed to validate pharmacy records;
- All pharmacies should be audited under the same standards;
- Audit period should not be infinite;
- Audit should not be scheduled during the 1st 5 days of the month;
- Audits must be conducted by a Florida licensed pharmacist;
- Audit standards should not exceed state laws;
- Extrapolation should not be used as a recoupment tool.

## Common Practices of PBM Auditors that Adversely Affects Pharmacy Businesses

**Disallowing Multiple Schedules on one prescription blank.**—Florida laws do not allow prescriptions from different controlled substance classifications to be written on the same blank however physicians continue to do so without fear of discipline. Such prescriptions are disallowed for payment even though the prescriber wrote it, the pharmacy purchased the drug and dispensed it and the patient received the drug and got better.

**Days Supply Penalty**—Pharmacists are being asked to be precise when “estimating” days supply of medications dispensed to patients. This is easier done for solid dosage forms but not exact for liquids such as expensive eye drops.

**Recoupment Penalty**—Unlike physician services demands for overpayment by pharmacies have included not only the small professional dispensing fees paid but the pharmacy must also pay back to the PBM the cost of the prescription drug purchased by the pharmacy that the patient had received for the treatment of diseases.

**Extended Audit Period**—The look back of audit records on occasion could go back several years. This is problematic for any business that is managed year to year on an operating budget. There could be a recoupment demand on dispensed prescriptions provided in a closed fiscal year.

**Patient Not Enrolled**—At the time that pharmacy services are rendered the insurance claim is processed in real time. There is a presumption that the patient is eligible for coverage and that the pharmacy will be paid. Pharmacies are being asked to pay back claims when it is discovered that the patient has a primary insurance carrier. In many cases this information is not disclosed at the time of service.

**Textual Numerical Penalty**—Florida has laws that require prescriptions to be written with the month in textual format. If the prescriber writes the prescription in textual format there is no penalty. There is a financial penalty for the pharmacy for dispensing this prescription. We are not aware of any pharmacy or pharmacist being disciplined by the Department for this.

**Clerical Errors Penalties** – In some cases there may be data entry errors related to how a prescription is processed and dispensed. An example would be if a pharmacy transmitted a code incorrectly that defines how the prescription order arrived in the pharmacy (for example, telephone order, written prescription, faxed in order or electronically transmitted to the pharmacy. If the pharmacy transmitted through the claims processing system the code that the prescription was faxed into the pharmacy and the actual records show that the prescription was telephoned in the pharmacy could be

penalized. Also there is a code that pharmacies transmit to third party programs that define whether the prescription was allowed to be interchanged or if the physician or patient preferred the branded drug. If that code was improperly transmitted again the pharmacy would be penalized even though that patient received the drug intended or prescribed.

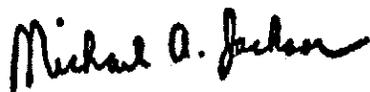
**Ideal Audit Period** – Our members have shared with us that auditors may appear at any time that a pharmacy is open for business. There are certain periods during each month that the pharmacy patient care services are at their peak which means that pharmacy staff would not be available to assist auditors in pulling records requested during an audit demand. Pharmacies are willing to bring in additional staff to assist with a smooth audit program however many audits that are unannounced are in some cases disruptive to the pharmacy's efforts to maintain quality patient care services.

The Florida Pharmacy Association supports auditing of pharmacies. Such a program should be designed to identify inappropriate business practices and verify that dollars spent on public and private health care programs and services are used as intended. We are aware that there are generally accepted accounting principles that are used in financial accounting and reporting however as pharmacy providers we are not aware of any generally accepted auditing principles for review of pharmacy records.

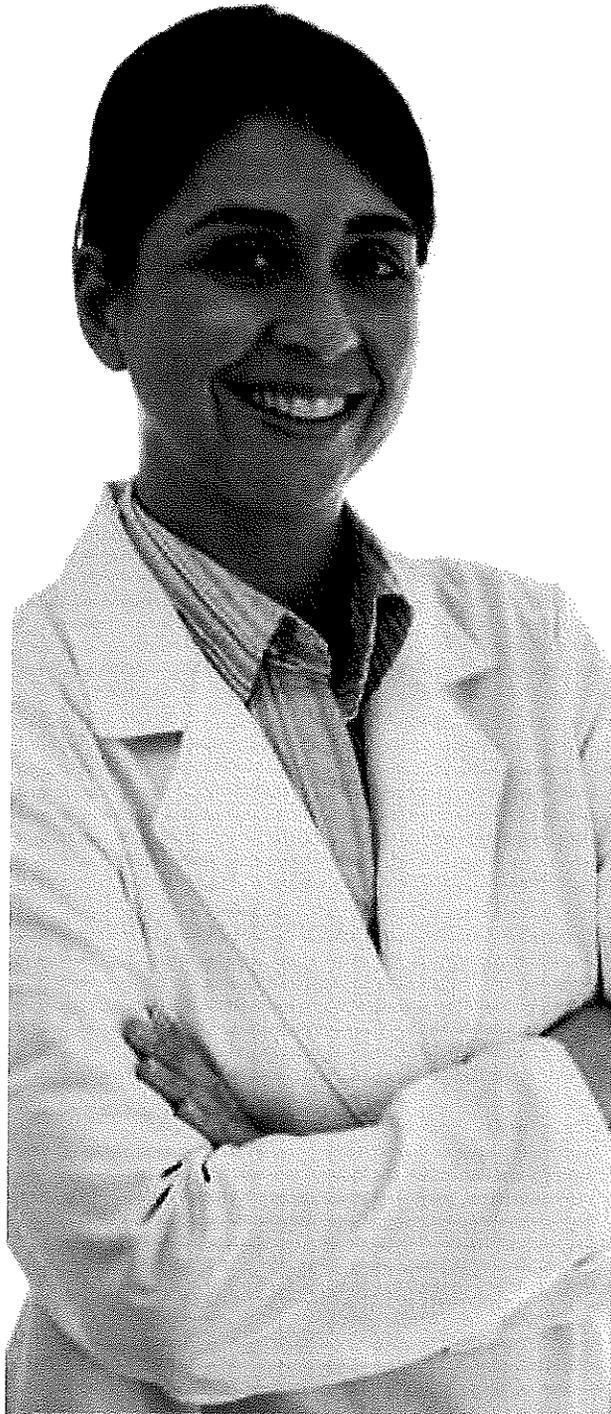
This legislation is currently in place for prescription services to Florida Medicaid patients in the fee for service program. We ask that the Florida legislature extend existing Florida laws on pharmacy auditing to all third party programs.

On behalf of the leadership and members of the Florida Pharmacy Association I thank you for the opportunity to share our comments with the Health Policy Committee.

With kindest regards,



Michael A. Jackson, BPharm, Executive Vice President and CEO



# Florida Pharmacy Concerns

## Pharmacy Audit Review

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February 11, 2014

Steve McCall, R.Ph., M.B.A.  
Director, Pharmacy Performance

\*Member\* refers to plan member, an individual eligible for prescription drug benefits under a plan.  
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## ■ CVS Caremark Pharmacy Audit

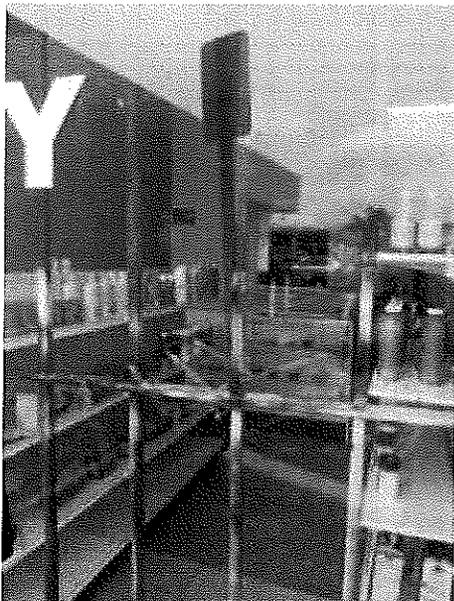


Pharmacy enrolled with CVS Caremark as a network pharmacy. Caremark audit showed large discrepancies. US Attorney prosecuted and defendant was sentenced to 144 months (12 years) in prison.

# ■ CVS Caremark Pharmacy Audit



Pharmacy audited by CVS Caremark and had major audit findings. The pharmacy was unable to produce invoices to show they purchased medications that were billed to plan sponsors and government payers.



## ■ CVS Caremark Pharmacy Audit

Pharmacy was audited and didn't have sufficient invoices. Mysteriously produced invoices from small wholesaler that turned out to have been "sold" to pharmacies to satisfy audits and government investigations.



# Craig's List Trend Continues

COMPOUNDING PHARMAC... Pharmacy Pharmacy local x

CL > south florida > miami / dade > all for sale / wanted > business/commercial - by owner

reply  prohibited<sup>[1]</sup> Posted: 22 days ago

★ **Pharmacy local - S1 (Hialeah)**

Pharmacy local for rent (not selling a Pharmacy) with fixtures in dispensing area and retail, is a huge local. Phamacies been here for more than 10 years. Space for compounding in back.Email me for an appointment to show it.

• Location: Hialeah

COMPOUNDING PHARMAC... Pharmacy Pharmacy local x

/ post /  
/ account /  
CL > south florida > miami / dade > all for sale / wanted > business/commercial - by owner

reply  prohibited<sup>[1]</sup> reply

Posted: 3 days ago

**Pharmacy - S200000 (Miami, SW 8 St )**

Pharmacy on sale almost new with only more than a year operating with all licenses and insurance in force including DEA . The Phamacy has low rent , Abacus software and full inventory to serve all our client . Excelent location surrounded by doctors offices and clinics with high potential to get more clients.  
Only serious inquires English - Spanish

Vendo Famacia casi nueva con mas de un año operando , tiene todas las licencias y seguros en vigencia (Incluyendo DEA ) . tiene una renta baja , Abacus software, inventario completo para servir a todos nuestros clientes, etc. Esta en una excelente ubicaciÃ³n, rodeado de oficinas mÃ©dicas , clÃnicas con un alto potencial para conseguir mÃ¡s clientes .

SÃ³lo personas interesadas

• Location: Miami, SW 8 St

# New Trend – Compounding Pharmacies

The screenshot shows a Windows Internet Explorer browser window. The title bar reads "COMPOUNDING PHARMACY OPPORTUNITY 32% ROI - Windows Internet Explorer". The address bar contains the URL "http://miami.craigslist.org/mdc/bfs/4283000706.html". The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The Favorites bar shows several bookmarks, including "Home - Enterprise Fraud Com...", "http-pharmcal.tripod.com-ind...", "Home - Total Rewards Comm...", "Hit Your Stride Walking", and "ahca AHCA Docs". The current page is a Craigslist listing with the breadcrumb "CL > south florida > miami / dade > all for sale / wanted > business/commercial - by owner". The listing includes a "reply" button, a "prohibited" icon, and the text "Posted: 27 days ago". The main heading is "★ COMPOUNDING PHARMACY OPPORTUNITY 32% ROI - \$50000". The body text describes an investment opportunity in a compounding pharmacy, mentioning a 36% net margin, existing clientele, and the need for an investor. It lists potential locations in NYC, Atlanta, and South Florida, and offers 8 months to profitability. The contact information is "Contact: Dr. Brian C. M.S., PhD cell: 404-551-9751". A note at the bottom of the listing says "do NOT contact me with unsolicited services or offers". At the bottom of the browser window, the status bar shows "Internet" and "100%".

COMPOUNDING PHARMACY OPPORTUNITY 32% ROI - Windows Internet Explorer

http://miami.craigslist.org/mdc/bfs/4283000706.html

File Edit View Favorites Tools Help

Home - Enterprise Fraud Com... http-pharmcal.tripod.com-ind... Home - Total Rewards Comm... Hit Your Stride Walking ahca AHCA Docs

COMPOUNDING PHARM... Pharmacy Pharmacy local

CL > south florida > miami / dade > all for sale / wanted > business/commercial - by owner

reply prohibited Posted: 27 days ago

★ **COMPOUNDING PHARMACY OPPORTUNITY 32% ROI - \$50000**

Open or expand your own pharmacy into a Compounding Pharmacy operation. 36% net margin! I have consulted the opening of over 22 succesful multi-million dollar medical clinics 15 Compounding pharmacies!!! Fully compliant models with National Franchise potential. Existing clientel for pharmacy operation. over 3million in accounts. Seeking Investor/s interested in placing money into an already developed and succesful business model. Great opportunity for investment. Proven tract record. It cost nothing to discuss options! opportunity exists for multi area openings in NYC, Atlanta or South Florida. 8 months to huge profitability! Compounding pharmacy? I have access to existing revenue stream? I am best Consultant in these fields. Legal, operations, Product development, Marketing, I have a team with 15 years experience in the Anti-Aging business. Looking to partner or consul Contact: Dr. Brian C. M.S., PhD cell: 404-551-9751

do NOT contact me with unsolicited services or offers

post id: 4283000706 posted: 27 days ago updated: a day ago email to friend best of

Internet 100%

**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.)

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

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BILL: SPB 7028

INTRODUCER: For consideration by the Health Policy Committee

SUBJECT: Telemedicine

DATE: January 24, 2014

REVISED: \_\_\_\_\_

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ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Lloyd	Stovall	HP	<b>Pre-meeting</b>

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**I. Summary:**

SPB 7028 creates the Florida Telemedicine Act (the act) and defines the key components for the practice of telemedicine. The act establishes a registration process for out of state, non-Florida licensed health care practitioners with a biennial fee and exemptions from registration for limited annual consultations, emergency services, and practitioner-to-practitioner consultations without the patient present.

The standard of care for telemedicine service coincides with health care services provided in-person. The nonemergency prescribing of a legend drug based solely on an online questionnaire is specifically prohibited and a controlled substance may not be prescribed through telemedicine for chronic, non-malignant pain.

Regulatory boards, or the Department of Health (department) if there is not an applicable board, may adopt rules to administer the act. Rules prohibiting telemedicine that are inconsistent with this act must be repealed.

The act requires a telemedicine provider to be responsible for the quality of any equipment or technology and to maintain records in accordance with federal and state laws.

Under the act, if a health insurer or health plan covers telemedicine services, then remuneration must equal the amount that would have been paid for in-person services. The amount of the reimbursement is to be determined by the individual telemedicine provider and the health insurer or health plan. The act allows a health plan or health insurer to impose a deductible, copayment or co-insurance if the amount charged does not exceed the amount charged for a non-telemedicine service. Health plans and health insurers may limit telemedicine coverage to in-network providers.

SPB 7028 authorizes the executive directors of the regulatory boards, along with the department to negotiate one or more interstate compacts to allow for the practice of telemedicine across state

lines. An annual report of any negotiated compacts is due to the Governor and Legislature on December 31, for ratification by the Legislature during the next session.

The Medicaid program must reimburse providers for telemedicine services in the same manner as provided for in-person services. Reimbursement amounts must be negotiated between the parties, to the extent permitted under federal law. Regardless of the amount negotiated, reimbursement for both the originating and the distant site should be considered based on the services provided during the encounter. A process for discontinuation of reimbursement for a Medicaid service through telemedicine is provided if the Agency for Health Care Administration (AHCA) can document a specific telemedicine service is not cost effective or does not meet the clinical needs of Medicaid recipients. The Medicaid provisions sunset on June 30, 2017.

The AHCA is required to submit a report on the usage and costs, including any savings, of telemedicine services provided to Medicaid recipients by January 1, 2017 to the President of the Senate, the Speaker of the House of Representatives and the minority leaders of the House and Senate.

The proposed bill's effective date is July 1, 2014.

## II. Present Situation:

Telemedicine utilizes various advances in communication technology to provide healthcare services through a variety of electronic mediums. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. According to the American Telemedicine Association, services provided through telemedicine include:<sup>1</sup>

- **Primary Care and Specialist Referral Services** - involves a primary care or allied health professional providing consultation with a patient or specialist assisting the primary care physician with a diagnosis. The process may involve live interactive video or the use of store and forward transmission of diagnostic images, vital signs, and/or video clips with patient data for later review.
- **Remote patient monitoring** - includes home telehealth, using devices to remotely collect and send data to home health agencies or remote diagnostic testing facilities.
- **Consumer medical and health information** - offers consumers specialized health information and online discussion groups for peer to peer support.
- **Medical education** - provides continuing medical education credits.

The term telehealth is also sometimes used interchangeably with telemedicine. Telehealth, however, generally refers to a wider range of health care services that may or may not include clinical services.<sup>2</sup> Telehealth often collectively defines the telecommunications equipment and

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<sup>1</sup> American Telemedicine Association, *What is Telemedicine?*, <http://www.americantelemed.org/learn/what-is-telemedicine> (last visited Jan. 6, 2014).

<sup>2</sup> Majerowicz, Anita; Tracy, Susan, "Telemedicine: Bridging Gaps in Healthcare Delivery," *Journal of AHIMA* 81, no. 5, (May 2010): 52-53, 56, [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_047324.hcsp?dDocName=bok1\\_047324](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047324.hcsp?dDocName=bok1_047324) (last visited Jan. 27, 2014).

technology that is utilized to collect and transmit the data for a telemedicine consultation or evaluation.

### **Board of Medicine Rulemaking**

Florida's Board of Medicine recently convened a Telemedicine Workgroup to review its rules on telemedicine which had not been amended since 2003. The 2003 rule focused on standards for the prescribing of medicine via the internet. A recently proposed revision to the telemedicine rule defines telemedicine, establishes a standard of care, prohibits the prescription of controlled substances, permits the establishment of a doctor-patient relationship via telemedicine, and exempts emergency medical services from the rule.<sup>3</sup>

### **Interstate Medical Licensure Compact**

The Federation of State Medical Boards (FSMB), a non-profit organization representing state medical boards that license and discipline allopathic and osteopathic physicians has drafted eight consensus principles aimed at addressing the process of licensing and regulating physicians who practice across state lines. Under an interstate compact, the participating state medical boards would retain their licensing and disciplining authority but would share essential information to streamline the process for those physicians who practice across state lines, including telemedicine.<sup>4</sup> The draft development of the Interstate Medical Licensure Compact, which would be voluntary on the part of both physicians and states, is expected in early Spring or Summer of 2014.<sup>5</sup>

### **Telemedicine in Other States**

As of January 2014, at least 20 states and the District of Columbia have mandated that private insurance plans cover telemedicine services at reimbursement rates equal to an in-person consultation.<sup>6</sup> Forty-four states reimburse under Medicaid for limited services, some restricting reimbursement to only rural or low provider access areas.<sup>7</sup> The breadth of state telemedicine laws vary from the very limited of authorizing store and forward services to mandating private insurance coverage and payment equivalency between face-to-face visits and telemedicine encounters. While nine states specifically issue a special-telemedicine-only license or certificate, several others may allow physicians from contiguous states to practice under certain conditions.<sup>8</sup>

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<sup>3</sup> See Notice of Proposed Rule 64B8-9.0141, F.A.C., published January 15, 2014.

<sup>4</sup> Federation of State Medical Boards, *Interstate Compact for Physician Licensure Moves Forward with Consensus Principles* (October 7, 2013), [http://www.fsmb.org/pdf/nr\\_interstate\\_compact.pdf](http://www.fsmb.org/pdf/nr_interstate_compact.pdf) (last visited Jan. 24, 2014).

<sup>5</sup> Federation of State Medical Boards, *State Medical Board Effort to Streamline Medical Licensing Gains Support in U.S. Senate* (January 14, 2014), [http://www.fsmb.org/pdf/interstate\\_compact\\_senators\\_january13C.pdf](http://www.fsmb.org/pdf/interstate_compact_senators_january13C.pdf) (last visited Jan. 24, 2014).

<sup>6</sup> American Telemedicine Association, *2014 State Telemedicine Legislative Tracking*, <http://www.americantelemed.org/docs/default-source/policy/state-telemedicine-legislation-matrix.pdf> (last visited Jan. 24, 2014).

<sup>7</sup> Id.

<sup>8</sup> Center for Connected Health Policy, *State Telehealth Laws and Reimbursement Policies*, (November 2013), p.6, <http://telehealthpolicy.us/sites/telehealthpolicy.us/files/uploader/50%20State%20Medicaid%20Update%20Nov.%202013%20-%20Rev.%2012-20.pdf> (last visited Jan. 24, 2014).

States have used telemedicine in correctional systems to eliminate the need to transport inmates in both Colorado and Wyoming.<sup>9</sup> In some cases, the health care professional is located in another location at the same facility and is able to interact with the inmate. This option addresses situations with violent inmates or handicap accessibility issues. Some jails use this same technology for online visits in place of face-to-face visitation, including the Alachua County jail in Florida.<sup>10</sup>

Rural counties have utilized telemedicine to fill the void for specialty care in their emergency rooms and to avoid costly and time consuming transfers of patients from smaller hospitals to the larger tertiary centers for care. In a California project, the rural hospitals' emergency rooms received video conference equipment to facilitate the telemedicine consultations as part of the study. The rural hospital physicians, nurses and parents were linked with pediatric critical care medicine specialists at the University of California, Davis.<sup>11</sup> Researchers at the university found that parents' satisfaction and perception of the quality of care received was significantly greater with telemedicine than with telephone guidance.<sup>12</sup>

### **Federal Provisions for Telemedicine**

Federal laws and regulations address telemedicine from several angles, from prescribing controlled substances and setting hospital emergency room guidelines, to establishing reimbursement guidelines for the Medicare program.

#### ***Prescribing Via the Internet***

Federal law specifically prohibits the issue of controlled substances prescribed via the internet without an in-person evaluation. The federal regulation under 21 CFR §829 specifically states:

No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.<sup>13</sup> However, the Ryan Haight Online Pharmacy Consumer Protection Act,<sup>14</sup> signed into law in October 2008, created an exception for the in-person medical evaluation for telemedicine practitioners. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

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<sup>9</sup> Government Computing News, *Prisons Turn to Telemedicine for Treating Inmates*, (May 21, 2013), <http://gcn.com/blogs/pulse/2013/05/prisons-telemedicine-treating-inmates.aspx> (last visited Jan. 28, 2014)

<sup>10</sup> Gainesville, Sun, *Now You Can Visit an Inmate From Home*, (Jan. 9, 2014), <http://www.gainesville.com/article/20140109/ARTICLES/140109711?p=1&tc=pg#gsc.tab=0> (last visited Jan. 28, 2014).

<sup>11</sup> *In Rural ERs, Kids Get Better Care with Telemedicine*, <http://www.futurity.org/in-rural-ers-kids-get-better-care-with-telemedicine> (last visited Jan. 28, 2014).

<sup>12</sup> *Id.*

<sup>13</sup> 21 CFR §829(e)(2).

<sup>14</sup> Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).

The Drug Enforcement Administration (DEA) of the federal Department of Justice issued its own definition of telemedicine in April of 2009 as required under the Haight Act.<sup>15</sup> The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

- The patient and the practitioner are located in separate locations;
- Patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substance via the Internet; and,
- Certain practitioners (Department of Veterans Affairs' employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.<sup>16</sup>

### *Medicare Coverage*

Specific telehealth services delivered at designated sites are covered under Medicare. The federal Centers for Medicare and Medicaid Services' regulations require both a distant site (location of physician delivering the service via telecommunications) and a separate originating site (location of the patient) under their definition of telehealth. Asynchronous "store and forward" activities are only reimbursed under Medicaid in federal demonstration projects.<sup>17</sup>

To qualify for Medicare reimbursement, the originating site must meet one of these qualifications:

- Located in a federally defined rural county;
- Designated rural health professional shortage area;<sup>18</sup> or,
- Identified as a participant in a federal telemedicine demonstration project as of December 21, 2000.<sup>19</sup>

Federal requirements provide additional qualifications for an originating site once one of the initial elements above has been satisfied. An originating site must be one of the following location types as further defined in federal law and regulation:

- The office of a physician or practitioner;
- A critical access hospital;
- A rural health clinic;
- A federally qualified health center;
- A hospital;
- A hospital-based or critical access hospital-based renal dialysis center (including satellites);
- A skilled nursing facility; and,

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<sup>15</sup> Id., at sec. 3(j).

<sup>16</sup> 21 CFR §802(54).

<sup>17</sup> Only two states have a federal demonstration project that meets these qualifications, Hawaii and Alaska.

<sup>18</sup> The rural definition was expanded through a final federal regulation released on December 10, 2013 to include health professional shortage areas located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. See 78 FR 74229, 74400-74402, 74812 (December 10, 2013).

<sup>19</sup> See 42 U.S.C. sec. 1395(m)(m)(4)(C)(i).

- A community mental health center.<sup>20</sup>

Reimbursement for the distant site is established as “an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.”<sup>21</sup>

Federal law also provides for a facility fee for the originating site that started and remained at \$20 through December 31, 2002 and then, by law, is subsequently increased each year by the percentage increase in the Medicare Economic Index or MEI. For calendar year 2014, the originating fee was 80 percent of the lesser of the actual charge or \$24.63.<sup>22</sup>

Telehealth services covered under Medicare include professional consultations, office visits, and office psychiatry services within certain health care procedure codes.<sup>23</sup> Practitioners eligible to bill for telehealth services include physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitians or nutrition specialists who are licensed to provide the service under state law.<sup>24</sup>

### **Telemedicine Services in Florida**

The University of Miami (UM) initiated telehealth services in 1973 and claims the first telehealth service in Florida, the first use of nurse practitioners in telemedicine in the nation, and the first telemedicine program in correctional facilities.<sup>25</sup> Today, UM has several initiatives in the areas of tele-dermatology, tele-trauma, humanitarian and disaster response relief telehealth, school telehealth services, and acute teleneurology or telestroke.<sup>26</sup> While some of the UM’s activities reach their local community, others reach outside of Florida including providing Haiti earthquake relief and teledermatology to cruise line employees. Telehealth communications are also used for monitoring patients in the hospital and conducting training exercises.

The UM also utilizes telemedicine to research the effectiveness of telemedicine in different trauma situations with the United States military. The research utilizes a robot which is operated from a control station using a joystick. The control station is on a laptop that allows the provider to operate the robot from any location with a wireless connection.<sup>27</sup> Lessons learned from this

<sup>20</sup> See 42 U.S.C. sec. 1395(m)(m)(4)(C)(ii).

<sup>21</sup> See 42 U.S.C. sec. 1395(m)(m)(2)(A).

<sup>22</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, *MLN Matters - News Flash #MM8533(December 20, 2013)*, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8533.pdf> (last visited: Jan 28, 2014).

<sup>23</sup> See 42 U.S.C. sec. (m)(m)(4)(F) for statutory authority and visit <http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/> for additional federal guidance.

<sup>24</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telehealth Services - Rural Health Fact Sheet Series*, December 2012, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsht.pdf> (last visited Jan. 27, 2014).

<sup>25</sup> University of Miami, Miller School of Medicine, *UM Telehealth - Our History*, <http://telehealth.med.miami.edu/about-us/our-history> (last visited Jan. 31, 2014).

<sup>26</sup> University of Miami, Miller School of Medicine, *UM Telehealth*, <http://telehealth.med.miami.edu/featured/teledermatology> (last visited Jan. 28, 2014).

<sup>27</sup> University of Miami, Miller School of Medicine, *UM Telehealth - Teletrauma*, <http://telehealth.med.miami.edu/featured/teletrauma> (last visited Jan. 31, 2014).

research are intended to provide assistance to deployed surgeons on the battlefield treating injured soldiers.

The UM along with other designated trauma centers participate in the Florida Emergency Trauma Telemedicine Network (FETTN). Coordinated by the department, the FETTN, facilitates the treatment of trauma patients between trauma centers and community or rural hospitals.<sup>28</sup> The FETTN allows for multiple interface options and currently 7 out of 25 trauma centers are part of the network.<sup>29</sup> In 2011-12, the seven Level 1 or Level 2 trauma centers that participated as a hub site, known as the location where the consulting physician is delivering the services, were Holmes Regional Medical Center, Tallahassee Memorial Hospital, Sacred Heart Hospital, University of Miami, Shands-Gainesville, Shands-Jacksonville, and Orlando Health.<sup>30</sup>

According to the department, the trauma centers and their satellites as well as the rural hospitals that currently participate in the FETTN are not reimbursed for the consultation and treatment services provided within the telemedicine network.

### ***Florida Medicaid Program***

Florida's Medicaid program reimburses for a limited number of telemedicine services by designated practitioners.<sup>31</sup> Audio only, email messages, facsimile transmissions, or communications with an enrollee through another mechanism other than the spoke site, known as the site where the patient is located, are not covered under Florida Medicaid.

Telemedicine is currently covered by Medicaid for the following services and settings:<sup>32</sup>

- Behavioral Health
  - Tele-psychiatry services for psychiatric medication management by practitioners licensed under s. 458 or 459, F.S.
  - Tele-behavioral health services for individual and family behavioral health therapy services by qualified practitioners licensed under chs. 490 or 491, F.S.
- Dental Services
  - Video conferencing between a registered dental hygienist employed by and under contract with a Medicaid-enrolled group provider and under the supervision of a supervising dentist.
  - Services include oral prophylaxis, topical fluoride, and oral hygiene instructions.
- Physician Services
  - Services provided using audio and video equipment that allow for two-way, real time interactive communication between physician and patient.

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<sup>28</sup> Florida Department of Health, *2014 Agency Legislative Bill Analysis of SB 70*, p.2, on file with the Senate Health Policy Committee (August 26, 2013).

<sup>29</sup> *Id.*, at .3.

<sup>30</sup> Florida Department of Health, *Long Range Program Plan* (September 28, 2012), on file with the Senate Health Policy Committee.

<sup>31</sup> Agency for Health Care Administration, *Highlights of Practitioner Services Coverage and Limitations Handbook Presentation*, Bureau of Medicaid Services, Summer 2013, p.30.

<sup>32</sup> Agency for Health Care Administration, *2014 Legislative Bill Analysis of SB 70*, November 7, 2013, p. 3, on file with the Senate Health Policy Committee.

- State plan waiver specifically authorizes reimbursement for specialty physician services for Children’s Medical Services Network.
- Physicians may bill for consultation services only provided via telemedicine.

The distant or hub site, where the provider is located, is eligible for reimbursement; the spoke site, where the patient is located, is not eligible for reimbursement unless a separate service is performed on the same day. Medicaid also requires that the referring physician and the patient be present during the consultation.<sup>33</sup>

Medicaid requires the following specific clinical records documentation to qualify for reimbursement as a telemedicine service:<sup>34</sup>

- A brief explanation of why services were not provided face-to-face;
- Documentation of telemedicine services, including results of assessment; and,
- A signed statement from the patient (or parent or guardian, if a child), indicating their choice to receive services through telemedicine.

Medicaid services are reimbursable only in the hospital outpatient, inpatient and physician office settings. During the 2013 Legislative Session, Medicaid provider enrollment requirements were revised to allow the enrollment of physicians actively licensed in Florida to interpret diagnostic testing results through telecommunications and information technology provided from a distance.<sup>35</sup>

Since 2006, the Children’s Medical Services Network (CMS Network) has been authorized to provide specified telemedicine services under Florida’s 1915(b) Medicaid Managed Care waiver. Authorized services include physician office visits (evaluation and management services) and consultation services already covered by the Medicaid state plan in select rural counties. Currently, the CMS Network provides telemedicine services in 57 of Florida’s 67 counties.<sup>36</sup>

The CMS Network works with the University of Florida’s (UF) pediatric endocrinology staff to provide telehealth services for enrollees with diabetes and other endocrinology diseases in the Daytona Beach service area.<sup>37</sup> Additional partnerships with the Institute for Child Health Policy at UF include referring children with special health care needs to community health centers for consults via telehealth for nutritional, neurological, and orthopedics in Southeast Florida.<sup>38</sup>

### ***Child Protection Teams***

The Child Protection Team (CPT) program under Children’s Medical Services utilizes a telemedicine network to perform child assessments. The CPT is a medically directed multi-disciplinary program that works with local Sheriff’s offices and the Department of Children and

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<sup>33</sup> Agency for Health Care Administration, *supra*, note 31, at 34.

<sup>34</sup> *Id.* at p.36.

<sup>35</sup> See Chapter 2013-150, L.O.F., sec. 1.

<sup>36</sup> Florida Department of Health, *supra*, note 28, at 2.

<sup>37</sup> Florida Department of Health, *Maternal and Child Health Block Grant Narrative for 2013*, <http://www.floridahealth.gov/healthy-people-and-families/womens-health/pregnancy/mch-fl-2013-1narrative.pdf>, p.21, (last visited: Jan. 31, 2014).

<sup>38</sup> *Id.*

Families in cases of child abuse and neglect to supplement investigative activities.<sup>39</sup> The CPT patient is seen at a remote site and a registered nurse assists with the medical exam. A physician or Advanced Registered Nurse Practitioner (ARNP) is located at the hub site and has responsibility for directing the exam.

Hub sites are comprehensive medical facilities that offer a wide range of medical and interdisciplinary staff whereas the remote sites tend to be smaller facilities that may lack medical diversity. In 2013, CPT telehealth services were available at 14 sites and 437 children were provided medical or other assessments via telemedicine technology.<sup>40</sup>

#### ***Other Department of Health Initiatives***

The department utilizes tele-radiology through the Tuberculosis (TB) Physician's Network.<sup>41</sup> The ability to read electronic chest X-Rays remotely can lead to a faster diagnosis, treatment and a reduction in the spread of the disease, according to the department. This service is not currently reimbursed by Medicaid.

#### **Compliance with Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Privacy rules were initially issued in 2000 by the Department of Health and Human Services and later modified in 2002. These rules address the use and disclosure of an individual's health information as well as create standards for privacy rights. Additional privacy and security measures were adopted in 2009 with the Health Information Technology for Economic Clinical Health (HITECH) Act.

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:

- Health plans;
- Health care providers;
- Health care clearinghouses; and,
- Business Associates.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which the medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration and funding was provided, in part, to strengthen infrastructure and tools to promote telemedicine.<sup>42</sup>

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that the equipment and technology is HIPAA compliant.

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<sup>39</sup> Florida Department of Health, *Child Protection Teams*, [http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child\\_protection\\_safety/child\\_protection\\_teams.html](http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html) (last visited Jan. 7, 2014).

<sup>40</sup> Florida Department of Health, *supra* note 37, at 21.

<sup>41</sup> Florida Department of Health, *supra* note 28, at 2.

<sup>42</sup> Public Law 111-5, sec. 3002(b)(2)(C)(iii) and sec. 3011(a)(4).

### III. Effect of Proposed Changes

**Section 1** designates ss. 465.4501-465.4507, F.S., as the “Florida Telemedicine Act.”

**Section 2** provides definitions for the Florida Telemedicine Act, including:

- Act
- Advanced Communications Technology
- Distant Site
- Encounter
- Health Care Provider
- In Person
- Originating Site
- Patient Presenter
- Store and forward
- Telemedicine
- Telemedicine provider

**Section 3** creates s. 456.4503, F.S., to establish a new registration process for an out of state health care practitioner who holds an active, unrestricted license in his or her state of residency in order to provide telemedicine services to a patient physically located in Florida. The registration process includes a biennial fee set by the applicable regulatory board in an amount not to exceed \$50.

The registration process for each health care practitioner type will be established by the applicable regulatory board for that profession, or if there is no regulatory board, then the department. Registration under this act will be treated the same as a license for disciplinary purposes and the health care provider must agree to make available any pertinent records upon the request of the applicable board, the department or any other federal or state regulatory authority. Failure to comply with a records request may result in revocation of the out of state practitioner’s registration or a fine, as established by the applicable board or the department, as applicable.

Registration under this act is only required for those health care practitioners who engage in telemedicine across state lines more than 10 times per calendar year. Emergency physician consultations are exempt from the registration requirements. Licensure is also not required for consultations between an out of state practitioner and an in-state practitioner for the transmission and review of digital images, pathology specimens, test results or other medical data related to a patient in this state.

A Health care practitioner acting within the scope of his or her practice may utilize telemedicine within his or her practice or act under the direction or supervision of an authorized practitioner. A health care practitioner or patient presenter using telemedicine technology at the direction and supervision of a physician may not be interpreted as practicing medicine without a license. Providers, however, are required to be trained and knowledgeable about the equipment being utilized. Failure to acquire appropriate training and knowledge is grounds for disciplinary action.

The regulatory boards, or the department if there is no board, may adopt rules to implement this act and are directed to repeal any rules that prohibit the practice of telemedicine. The boards may also adopt rules regarding patient presenters but may not require the use of a presenter, if special skills and training are not needed for the patient to participate in the encounter.

**Section 4** creates s. 456.4504, F.S., to specify that the standard of care for the delivery of telemedicine services shall be the same as if the services were delivered in person.

The proposed bill references the standard of care in s. 766.102, F.S. That section of law addresses medical negligence and provides:

The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

The telemedicine provider is responsible for the quality of the telemedicine equipment and technology and its safe use. Telemedicine equipment must be able to provide the health care provider the same information, at a minimum, that would have been obtained in an in-person encounter. The equipment and technology must enable the telemedicine provider to meet or exceed the prevailing standard of care for the practitioner's profession.

The health care provider is not required to conduct a patient history or physical exam before the telemedicine encounter as long as the telemedicine evaluation meets the community standard of care for the services provided.

The act prohibits prescribing a legend drug based solely on an electronic questionnaire without a visual examination. To do so is a failure to practice medicine with the level of care, skill and treatment recognized by the reasonably prudent practitioner and is not authorized under this act. Additionally, a practitioner may not prescribe a controlled substance through the use of telemedicine for chronic, non-malignant pain.

Medical record-keeping requirements must be kept in the same manner as an in-person encounter under federal and state law. All records generated, including audio, video, electronic or other means must conform to confidentiality and record-keeping laws of this state, regardless of the patient's location. Telemedicine technology must be encrypted and include a record-keeping program to verify each interaction.

If a third party vendor is used by a telemedicine provider, a business associate agreement is required. The act requires that the third party vendor comply with the HITECH Act. For patient owned technology, the telemedicine provider is responsible for ensuring that the equipment meets the same requirements under the HITECH Act and is appropriate for the medical services being rendered.

**Section 5** creates s. 456.4505, F.S., to establish reimbursement guidelines for telemedicine services reimbursed through health insurance policies or health plans. Mandatory coverage for

telemedicine services under health insurance plans and policies is not required under the act; however, if covered, then the services must be paid in an amount equal to the amount the health care provider would have received had the services been provided without the use of telemedicine services. The level of reimbursement for telemedicine services is to be determined between the health care provider and the health insurance plan.

A health plan or health insurer may impose a deductible, copay, or a coinsurance for telemedicine as long as that cost does not exceed the amount charged for an in-person encounter for the same health care service. A health insurance policy or plan may also limit telemedicine coverage to only those providers within the insurer's network, without regard to the provisions of ss. 627.6471 and 627.6472, F.S.

**Section 6** creates s. 456.4506, F.S., to authorize the executive directors of the various regulatory boards for health care professions and the department to negotiate interstate compacts for the provision of telemedicine services across state lines. Annually, the department is required to present a status report to the Governor, the President of the Senate, and the Speaker of the House of Representatives of any negotiated compacts for potential ratification by the Legislature. The report is due each December 31.

**Section 7** creates s. 456.4507, F.S., to establish a requirement for the AHCA to reimburse for telemedicine services under Medicaid. Telemedicine services are to be reimbursed in the same manner and in an equivalent amount to Medicaid services provided in-person under parts III (Medicaid) and IV (Medicaid Managed Care) of ch. 409, F.S. An exception to this requirement is provided if the AHCA determines a service that is delivered through telemedicine is not cost effective or does not meet the clinical needs of recipients. If, after implementation, the AHCA documents this determination, then coverage for that particular service may be discontinued.

Under this section, reimbursement for Medicaid services delivered via telemedicine shall be negotiated between the parties; however, both the originating site and distant site should receive compensation based on the services rendered.

The AHCA is also required to submit a usage and cost report on telemedicine services in the Medicaid program. The report is due to the President of the Senate, Speaker of the House of Representatives, and the minority leaders by January 1, 2017.

This section relating to telemedicine services under the Medicaid program sunsets on June 30, 2017.

**Section 8** provides an effective date of July 1, 2014.

#### **IV. Constitutional Issues:**

##### **A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

**V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Out of state practitioners not currently licensed to practice in Florida would pay a biennial fee of \$50 to register to provide professional services via telemedicine to patients in the state. It is unknown how many out of state practitioners would register under this act.

The potential expansion of telemedicine reimbursement opportunities under both private insurance coverage and Medicaid could facilitate a growth in health care provider fees for private sector health care providers, especially those providers that are currently providing these services now and not receiving any reimbursement.

Additionally, health care technology companies that provide the equipment for these services may see an increase in demand from health care practitioners for new equipment and maintenance needs of any existing equipment.

C. Government Sector Impact:

For SB 70, which had a similar provision for telemedicine coverage of Medicaid services, the AHCA provided an indeterminate fiscal impact because the rulemaking in SB 70 had been delegated to the department and both costs and savings would be associated with the bill's provisions. The expected savings were based on possible efficiencies, improvements in disease management, and improved patient outcomes that resulted from telemedicine services.<sup>43</sup>

An increase in the services covered by telemedicine could also lead to an indeterminate increase in utilization and costs. SPB 7028 broadens the number of services available through telemedicine.<sup>44</sup>

The department indicated in its analysis of SB 70 that a potential increase in Medicaid reimbursement funds for consultation and treatment under Medicaid could be achieved

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<sup>43</sup> Agency for Health Care Administration, *supra*, note 32, at 7.

<sup>44</sup> *Id.*, p. 8.

for the TB project. According to the department, the estimated revenue impact to the state would be \$103,190.<sup>45</sup>

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

There are numerous other sections of state law that refer to “in person” or “face to face” requirements for certain medical services or health care related activities. While SPB 7028 defines “in person” for purposes of the Florida Telemedicine Act, there are other usages of this phrase in statute.

**VIII. Statutes Affected:**

This bill creates the following sections of the Florida Statutes: 456.4501, 456.4502, 456.4503, 456.4504, 456.4505, 456.4506, and 456.4507.

**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.

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

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<sup>45</sup> Florida Department of Health, *supra* note 28, at 5.

FOR CONSIDERATION By the Committee on Health Policy

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1 A bill to be entitled  
2 An act relating to telemedicine; creating s. 456.4501,  
3 F.S.; providing a short title, the "Florida  
4 Telemedicine Act"; creating s. 456.4502, F.S.;  
5 defining terms applicable to the act; creating s.  
6 456.4503, F.S.; creating licensure and registration  
7 requirements; providing applicability; authorizing the  
8 health care boards and the Department of Health to  
9 adopt rules; creating s. 456.4504, F.S.; providing  
10 standards and prohibitions for the provision of  
11 telemedicine; creating s. 456.4505, F.S.; providing  
12 health insurer and health plan reimbursement  
13 requirements for telemedicine; creating s. 456.4506,  
14 F.S.; providing legislative findings; authorizing the  
15 regulatory boards and the department to negotiate  
16 interstate compacts for telemedicine; requiring an  
17 annual report to the Governor and the Legislature on  
18 the status of such compacts; requiring legislative  
19 ratification of such compacts; creating s. 456.4507,  
20 F.S.; providing requirements for reimbursement of  
21 telemedicine services under the Medicaid program;  
22 requiring a report to the Legislature on the usage and  
23 costs of telemedicine in Medicaid by a certain date;  
24 providing for future repeal; providing an effective  
25 date.

26  
27 Be It Enacted by the Legislature of the State of Florida:

28  
29 Section 1. Section 456.4501, Florida Statutes, is created

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30 to read:

31 456.4501 Short title.—Sections 465.4501-465.4507 may be  
32 cited as the "Florida Telemedicine Act."

33 Section 2. Section 456.4502, Florida Statutes, is created  
34 to read:

35 456.4502 Definitions.— As used in this act, the term:

36 (1) "Act" means the Florida Telemedicine Act.

37 (2) "Advanced communications technology" means:

38 (a) Compressed digital interactive video audio, or data  
39 transmissions;

40 (b) Real-time synchronous video or web-conferencing  
41 communications;

42 (c) Secure web-based communications;

43 (d) Still-image capture or asynchronous store and forward;

44 (e) Health care service transmissions supported by mobile  
45 devices (mHealth); or

46 (f) Other technology that facilitates access to health care  
47 services or medical specialty expertise.

48 (3) "Distant site" means the location at which the  
49 telemedicine provider delivering the health care service is  
50 located at the time the service is provided via telemedicine.

51 (4) "Encounter" means an examination, consultation,  
52 monitoring, or other health care service.

53 (5) "Health care provider" means a health care practitioner  
54 or out-of-state licensed individual who provides health care  
55 services within the scope of his or her professional license.

56 (6) "In person" means that a patient is in the physical  
57 presence of the health care provider without regard to whether  
58 portions of the encounter are conducted by other providers.

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59       (7) "Originating site" means the location of the patient at  
60 the time a health care service is being furnished via  
61 telemedicine. The originating site may also mean the location at  
62 which the advanced communications technology equipment that  
63 facilitates the provision of telemedicine is located, with or  
64 without the patient being present. An originating site is one of  
65 the following:

66       (a) The office of a health care provider.

67       (b) A critical access hospital as defined in s. 1861(mm) (1)  
68 of the Social Security Act.

69       (c) A rural health clinic as defined in s. 1861(aa) (2) of  
70 the Social Security Act.

71       (d) A federally qualified health center as defined in s.  
72 1861(aa) (4) of the Social Security Act.

73       (e) A hospital as defined in s. 1861(e) of the Social  
74 Security Act.

75       (f) A hospital-based or critical access hospital-based  
76 renal dialysis center, including satellites.

77       (g) A community mental health center as defined in s.  
78 1861(ff) (3) (B) of the Social Security Act.

79       (h) A correctional facility.

80       (i) If the security and privacy of the advanced  
81 communications technology can be verified by the distant site,  
82 the patient's home.

83       (8) "Patient presenter" means an individual who has  
84 clinical background training in the use of advanced  
85 communications technology equipment and who is available at the  
86 originating site to present the patient, manage the cameras or  
87 equipment, and perform any hands-on activity necessary to

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88 successfully complete the telemedicine encounter.

89 (9) "Store and forward" means the type of telemedicine  
90 encounter that uses still digital images of patient data for  
91 rendering a medical opinion or diagnosis. The term includes the  
92 asynchronous transmission of clinical data from one site to  
93 another.

94 (10) "Telemedicine" means the use of advanced  
95 communications technology by a health care provider or by a  
96 health care provider acting under an appropriate delegation or  
97 supervision as may be required by the appropriate board, or the  
98 department if there is no board, to provide a health care  
99 services. Services provided through telemedicine may include  
100 patient assessment, diagnosis, consultation, treatment,  
101 prescription of medicine, transfer of medical data, or other  
102 medical-related services. The term does not include audio-only  
103 calls, e-mail messages, or facsimile transmissions. Telemedicine  
104 also includes telehealth and telemonitoring.

105 (11) "Telemedicine provider" means a health care provider  
106 who provides telemedicine services to a patient physically  
107 located in this state.

108 Section 3. Section 456.4503, Florida Statutes, is created  
109 to read:

110 456.4503 Licensure and registration requirements.—

111 (1) An out-of-state health care provider who provides  
112 telemedicine across state lines to a patient physically located  
113 in this state must have a Florida license to practice a health  
114 care profession or must meet the following telemedicine  
115 requirements:

116 (a) Hold an unrestricted active license to practice his or

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117 her profession in the health care provider's state of residency;  
118 and

119 (b) Complete telemedicine registration with the department  
120 through a procedure established by the appropriate board for the  
121 health care provider's area of practice, or the department if  
122 there is no board; and

123 (c) Pay a biennial registration fee set by the applicable  
124 board, not to exceed \$50.

125 (2) A registration issued under this section, regardless of  
126 the location of the telemedicine provider, shall be treated as a  
127 license for disciplinary action by the appropriate board in this  
128 state, or the department if there is no board. A telemedicine  
129 provider licensed in this state or registered to practice  
130 telemedicine in accordance with this act is subject to this act,  
131 the jurisdiction of this state's applicable board, other legal  
132 and regulatory authorities in this state, as applicable, and the  
133 jurisdiction of the courts of this state. The telemedicine  
134 provider shall also make available any pertinent records upon  
135 request of the board, the department, or the regulatory  
136 authority. Failure to comply with such request may result in  
137 revocation of the telemedicine provider's license or  
138 registration at the discretion of the applicable board, or the  
139 department if there is no board, or a fine as established by the  
140 applicable board or the department, as applicable.

141 (3) Registration as a telemedicine provider is required  
142 only for those out-of-state health care providers who engage in  
143 the practice of telemedicine across state lines more than 10  
144 times per calendar year. Physician consultations that occur on  
145 an emergency basis are exempt from registration requirements.

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146       (4) This section does not prohibit or require licensure or  
147 registration for consultations between an out-of-state health  
148 care provider and a health care practitioner in this state or  
149 for the transmission and review of digital images, pathology  
150 specimens, test results, or other medical data by an out-of-  
151 state health care provider or other qualified providers related  
152 to the care of a patient in this state.

153       (5) This section does not preclude a health care provider  
154 who acts within the scope of his or her practice from using the  
155 technology of telemedicine within his or her practice or under  
156 the direction and supervision of another health care provider  
157 whose scope of practice includes the use of such technology. A  
158 health care provider or patient presenter acting under the  
159 direction and supervision of a physician through the use of  
160 telemedicine may not be interpreted as practicing medicine  
161 without a license. However, a health care provider must be  
162 trained in, educated on, and knowledgeable about the procedure  
163 and technology and may not perform duties for which the  
164 practitioner does not have sufficient training, education, and  
165 knowledge. Failure to have adequate training, education, and  
166 knowledge is grounds for disciplinary action by the appropriate  
167 board or the department if there is no board.

168       (6) The boards, or the department if there is no board, may  
169 adopt rules to administer the requirements of this act and must  
170 repeal rules that are inconsistent with this act, including  
171 rules that prohibit the use of telemedicine in this state. The  
172 appropriate board, or the department if there is no board, may  
173 also develop standards and adopt rules relating to requirements  
174 for patient presenters. Such rules may not require the use of

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175 patient presenters in telemedicine services if special skills or  
176 training is not needed for a patient to participate in the  
177 encounter.

178 Section 4. Section 456.4504, Florida Statutes, is created  
179 to read:

180 456.4504 Telemedicine standards.—

181 (1) The standard of care as provided in s. 766.102 is the  
182 same regardless of whether a health care provider provides  
183 health care services in person or by telemedicine. The  
184 applicable board for each health care provider, or the  
185 department if there is no board, may adopt rules specifically  
186 related to the standard of care for telemedicine.

187 (2) A telemedicine provider providing telemedicine services  
188 under this act is responsible for the quality of the equipment  
189 and technology employed and for its safe use. Telemedicine  
190 equipment and advanced communications technology must, at a  
191 minimum, be able to provide the same information to the  
192 telemedicine provider as the information that would be obtained  
193 in an in-person encounter with a health care provider which  
194 enables the telemedicine provider to meet or exceed the  
195 prevailing standard of care for the practice of the profession.

196 (3) The telemedicine provider is not required to conduct a  
197 patient history or physical examination of the patient before  
198 engaging in a telemedicine encounter if the telemedicine  
199 provider conducts a patient evaluation sufficient to meet the  
200 community standard of care for the services provided.

201 (4) For the purposes of this act, the nonemergency  
202 prescribing of a legend drug based solely on an electronic  
203 questionnaire without a visual examination is considered a

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204 failure to practice medicine with the level of care, skill, and  
205 treatment which is recognized by a reasonably prudent physician  
206 or other authorized practitioners and is not authorized under  
207 this act.

208 (5) A controlled substance may not be prescribed through  
209 the use of telemedicine for chronic, nonmalignant pain.

210 (6) Medical records must be kept by each telemedicine  
211 provider that participates in a patient telemedicine encounter  
212 to the same extent as required for an in-person encounter under  
213 state and federal law. Telemedicine providers are encouraged to  
214 create electronic health records to record the encounter and to  
215 transmit information in the most efficient manner possible.

216 (7) Any medical records generated, including records  
217 maintained via video, audio, electronic, or other means, due to  
218 a telemedicine encounter must conform to the confidentiality and  
219 recordkeeping requirements of federal law, nationally recognized  
220 health care accreditation organizations, and the laws and rules  
221 of this state regardless of where the medical records of a  
222 patient in this state are maintained.

223 (8) Telemedicine technology used by a telemedicine provider  
224 must be encrypted and must use a recordkeeping program to verify  
225 each interaction.

226 (9) In those situations in which a telemedicine provider  
227 uses telemedicine technology provided by a third-party vendor,  
228 the telemedicine provider must:

229 (a) Require a business associate agreement with the third-  
230 party vendor; and

231 (b) Ensure that the third-party vendor complies with the  
232 administrative, physical, and technical safeguards and standards

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233 set forth by the Health Information Technology for Economic and  
234 Clinical Health (HITECH) Act and by federal regulations  
235 implemented pursuant to HITECH.

236 (10) If a patient provides any of the telemedicine  
237 technology, such as a patient-owned smartphone, tablet, laptop,  
238 desktop computer, or video equipment, the telemedicine provider  
239 must take steps to ensure that such technology:

240 (a) Complies with the administrative, physical, and  
241 technical safeguards set forth by HITECH and by federal  
242 regulations implemented pursuant to HITECH; and

243 (b) Is appropriate for the medical discipline for which the  
244 technology is provided.

245 Section 5. Section 456.4505, Florida Statutes, is created  
246 to read:

247 456.4505 Requirements for reimbursement.-

248 (1) If health care services provided through telemedicine  
249 are an included benefit in a health insurance policy or health  
250 plan coverage, such services must be paid in an amount equal to  
251 the amount that a health care provider would have been paid had  
252 such services been furnished without the use of advanced  
253 communications technology.

254 (2) Reimbursement amounts for telemedicine providers at the  
255 distant site and the originating site and any originating fees  
256 are to be determined between the individual telemedicine  
257 provider and the health insurer or health plan.

258 (3) This section does not preclude a health insurer or  
259 health plan from imposing a deductible, a copayment, or a  
260 coinsurance requirement for a health care service provided  
261 through telemedicine if the deductible, copayment, or

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262 coinsurance does not exceed the amount applicable to an in-  
263 person encounter for the same health care service.

264 (4) A health insurance policy or health plan may limit  
265 coverage for health care services that are provided through  
266 telemedicine to telemedicine providers that are in a network  
267 approved by the health insurer or health plan without regard to  
268 s. 627.6471 or s. 627.6472.

269 Section 6. Section 456.4506, Florida Statutes, is created  
270 to read:

271 456.4506 Interstate compacts for telemedicine.—The  
272 Legislature finds that lack of access to high-quality,  
273 affordable health care services is an increasing problem, both  
274 in this state and nationwide. The Legislature finds that this  
275 problem could be alleviated by greater interstate cooperation  
276 among, and by the mobility of, health care providers through the  
277 use of telemedicine. Therefore, the executive directors of the  
278 boards, together with the department, may negotiate one or more  
279 interstate compacts for the provision of telemedicine services  
280 across state lines. The department shall annually submit a  
281 report on the status of any negotiated compacts to the Governor,  
282 the President of the Senate, and the Speaker of the House of  
283 Representatives. Any negotiated compacts shall be submitted by  
284 December 31 for ratification by the Legislature during the next  
285 regular legislative session.

286 Section 7. Section 456.4507, Florida Statutes, is created  
287 to read:

288 456.4507 Telemedicine services under Medicaid.—

289 (1) The Agency for Health Care Administration shall  
290 reimburse Medicaid services provided through telemedicine in the

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291 same manner and equivalent to Medicaid services provided in  
292 person under parts III and IV of chapter 409, except as provided  
293 in subsection (6).

294 (2) Telemedicine services reimbursed under Medicaid must  
295 meet the standards and requirements of this act.

296 (3) Except as provided in subsection (6), the agency may  
297 not require in-person contact between a health care provider and  
298 Medicaid recipient as a prerequisite for payment for services  
299 appropriately provided through telemedicine in accordance with  
300 generally accepted health care practices and standards  
301 prevailing in the applicable health care community at the time  
302 the services are provided.

303 (4) A Medicaid service that is provided through a fee-for-  
304 service or managed care program may not be denied as a  
305 creditable Medicaid service solely because that service is  
306 provided through telemedicine.

307 (5) Reimbursement of telemedicine services under Medicaid  
308 shall be the amount negotiated between the parties involved to  
309 the extent permitted under state and federal law. Regardless of  
310 the reimbursement methodology or amount, telemedicine providers  
311 located at the originating site and the distant site should both  
312 receive reimbursement based on the services rendered, if any,  
313 during the telemedicine encounter.

314 (6) If, after implementation, the agency determines that  
315 the delivery of a particular service through telemedicine is not  
316 cost-effective or does not adequately meet the clinical needs of  
317 recipients and the determination has been documented, the agency  
318 may discontinue Medicaid reimbursement for that telemedicine  
319 service.

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320       (7) The agency shall submit a report on the usage and  
321 costs, including savings, if any, associated with the provision  
322 of health care services through telemedicine under the Medicaid  
323 program by January 1, 2017, to the President of the Senate, the  
324 Speaker of the House of Representatives, and the minority  
325 leaders of the Senate and House of Representatives.

326       (8) This section is repealed June 30, 2017.

327       Section 8. This act shall take effect July 1, 2014.

# CourtSmart Tag Report

Room: KN 412  
Caption: Senate Health Policy

Case:  
Judge:

Type:

Started: 2/11/2014 2:10:01 PM

Ends: 2/11/2014 3:18:36 PM

Length: 01:08:36

2:10:04 PM Meeting Called to Order  
2:10:15 PM Roll Call  
2:10:50 PM Sen. Sobel opens  
2:11:10 PM Tab 3- SB 306 Community Health Workers  
2:11:56 PM Sen. Braynon explains bill  
2:12:54 PM Barcode 187860 Amendment  
2:13:07 PM Sen. Braynon explains amendment  
2:13:20 PM Sen. Sobel asks for questions  
2:13:41 PM AM adopted  
2:13:49 PM Brian Pitts, Justice-2-Jesus waives in support  
2:14:00 PM Bill waives closed  
2:14:05 PM Roll Call on SB 306  
2:14:23 PM Show Bill Passing  
2:14:28 PM Tab 2- Public Records/Yellow Dot Critical Motorist Medical Information Program  
2:15:13 PM Barcode 332506 amendment  
2:15:39 PM Sen. Sobel asks for questions  
2:15:53 PM AM adopted  
2:16:01 PM Brian Pitts, Justice-2-Jesus waive in support  
2:16:14 PM Sen. Braynon moves bill as committee substitute  
2:16:22 PM Roll Call  
2:16:35 PM Show Bill Passing  
2:16:44 PM Tab 4- Background Screening  
2:17:32 PM Bill is explained  
2:18:14 PM Barcode 378632 is explained  
2:18:28 PM Sen. Sobel asks for questions, testimony, debate  
2:18:42 PM AM adopted  
2:18:45 PM Barcode 569918 is explained  
2:19:13 PM Sen. Sobel asks for questions  
2:19:17 PM AM adopted  
2:19:30 PM Sen. Joyner asks question  
2:20:08 PM Brian Pitts, Justice-2-Jesus waives in support  
2:20:27 PM Tanya Cooper, DOE, waives in support  
2:20:42 PM Dana Farmer, Disability Rights Florida, waives in support  
2:20:59 PM Sen. Joyner moves bill as committee substitute  
2:21:09 PM Roll Call  
2:21:24 PM Tab 5- SB 702 Pharmacy Audits  
2:21:48 PM Sen. Flores explains bill  
2:23:06 PM Sen. Sobel asks for questions  
2:23:28 PM Testimony by Bill Mincy, PPSC Independent Pharmacy Owners, VP  
2:28:42 PM Sen. Sobel thanks speaker and asks for questions  
2:28:54 PM Sen. Sobel asks about duration  
2:29:02 PM Mr. Mincy responds  
2:29:12 PM Testimony by Jim Powers, waives in favor  
2:29:29 PM Testimony by Joy Ryan, Prime Therapeutics  
2:31:09 PM Sen. Sobel asks for questions  
2:31:21 PM Testimony by Steven McCall, CVS Caremark  
2:35:44 PM Sen. Sobel asks for questions and asks question  
2:36:12 PM Mr. McCall responds  
2:36:27 PM Sen. Sobel asks follow-up question  
2:36:36 PM Mr. McCall responds  
2:36:45 PM Sen. Sobel asks question about compounds  
2:36:54 PM Mr. McCall responds

2:37:48 PM Sen. Sobel asks follow-up question  
2:37:54 PM Mr. McCall responds  
2:37:58 PM Sen. Sobel asks question  
2:38:11 PM Mr. McCall responds  
2:39:21 PM Sen. Sobel asks question about need for compounds  
2:39:35 PM Mr. McCall responds  
2:40:02 PM Sen. Sobel thanks speaker and asks for questions  
2:40:11 PM Larry Williams, American Pharmacy Cooperative waives in support  
2:40:32 PM Claudia Davant, Florida Pharmacy Association waives in support  
2:40:49 PM Testimony by Jonathan Hickman, Florida Pharmacy Association  
2:41:56 PM Sen. Brandes asks question  
2:42:02 PM Mr. Hickman responds  
2:43:39 PM Sen. Brandes asks follow-up question about high risk pharmacies  
2:43:49 PM Mr. Hickman responds  
2:44:24 PM Sen. Sobel thanks speaker  
2:44:34 PM Larry Gonzalez, FL Society of Health, waives in support  
2:44:51 PM Sen. Galvano makes comment claiming bill goes too far  
2:45:40 PM Sen. Sobel asks for other comments  
2:45:46 PM Sen. Flores closes on bill  
2:46:04 PM Roll Call on SB 702  
2:46:24 PM Show Bill Passing  
2:46:39 PM Tab 6- SPB 7028 Telemedicine  
2:47:05 PM Bill is explained  
2:48:30 PM Sen. Sobel asks for questions  
2:48:58 PM Testimony by Chris Nuland, FL Chapter, American College of Surgeons  
2:50:23 PM Testimony by John Brandt, FL Chapter of the American College of Physicians  
2:51:09 PM Sen. Joyner asks question  
2:51:36 PM Dr. Brandt responds  
2:53:11 PM Sen. Joyner asks follow-up question about certifications  
2:53:22 PM Dr. Brandt responds  
2:54:14 PM Sen. Joyner makes comment  
2:56:02 PM Sen. Sobel asks question about out of state physicans  
2:56:23 PM Dr. Brandt responds  
2:58:04 PM Sen. Sobel asks follow-up question  
2:58:12 PM Dr. Brandt responds  
3:00:06 PM Sen. Sobel thanks speaker  
3:00:21 PM Testimony by Stan Whittaker, Florida Association of Nurse Practitioners  
3:01:45 PM Sen. Joyner asks question about the name 'telehealth'  
3:02:17 PM Testimony by Layne Smith, Mayo Clinic  
3:07:20 PM Sen. Sobel asks for questions  
3:07:24 PM Sen. Joyner asks question about expansion  
3:07:38 PM Mr. Smith responds  
3:07:53 PM Testimony by Larry Gonzalez, FL Occupational Therapy Association  
3:09:17 PM Testimony by Kim Landry, Emergency Physician  
3:15:14 PM Sen. Sobel asks for questions and poses one  
3:15:31 PM Mr. Landry responds with regard to quality of care  
3:16:25 PM Sen. Sobel asks follow-up question  
3:16:31 PM Dr. Landry responds  
3:16:38 PM Sen. Sobel voices concern and asks question about wifi  
3:16:48 PM Dr. Landry responds  
3:17:54 PM Sen. Sobel asks question  
3:17:58 PM Dr. Landry responds with regard to investments  
3:18:27 PM Sen Joyner moves we rise



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**  
Communications, Energy, and Public Utilities, Vice  
Chair  
Appropriations Subcommittee on Criminal and  
Civil Justice  
Appropriations Subcommittee on Health and Human  
Services  
Transportation  
Health Policy  
Agriculture  
Transportation

**JOINT COMMITTEE:**  
Joint Committee on Administrative Procedures

**SENATOR RENE GARCIA**  
38th District

The Honorable Aaron Bean  
302 Senate Office Building  
404 South Monroe Street  
Tallahassee, FL 32399-1100

Dear Chairman Bean:

Due to unforeseen circumstances; I will not be able to attend the Health Policy Committee meeting scheduled for Tuesday February 11, 2014. Please do not hesitate to contact my office if you have any questions. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "René García".

State Senator René García  
District 38  
RG:dm

A handwritten signature in black ink, appearing to read "Eleanor Sobel", written over a horizontal line.

CC: Sandra Stovall, Staff Director

**REPLY TO:**

- 2100 Coral Way, Suite 505, Miami, Florida 33145 (305) 643-7200
- 312 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5040

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**DON GAETZ**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore