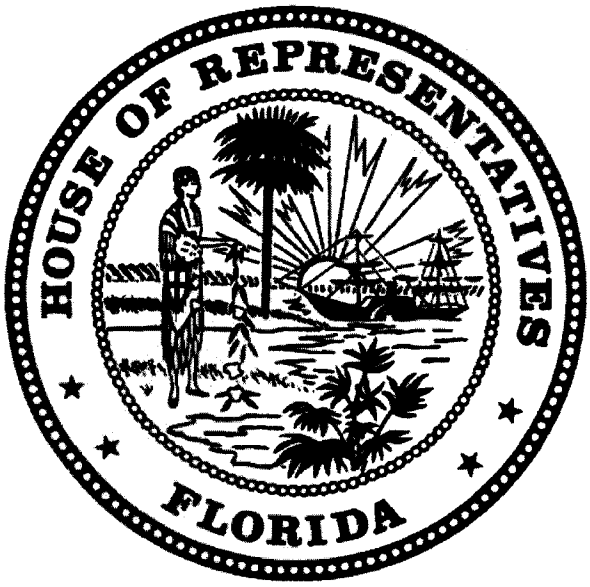

Health Care Appropriations Subcommittee

Tuesday, March 21, 2017
8:00 AM – 11:00 AM
Sumner Hall (404 HOB)

Meeting Packet

Part 1

Richard Corcoran
Speaker

Jason Brodeur
Chair

The Florida House of Representatives

Appropriations Committee
Health Care Appropriations Subcommittee

Richard Corcoran
Speaker

Jason Brodeur
Chair

March 21, 2017

AGENDA
8:00 a.m. – 11:00 a.m.
Sumner Hall (404)

I. Call to Order/Roll Call

II. Opening Remarks

III. Consideration of the following bills(s)

- CS/HB 23 Public Assistance by Children, Families & Seniors Subcommittee, Eagle
- CS/HB 229 Programs for Impaired Health Care Practitioners by Health Quality Subcommittee, Byrd
- CS/HB 619 Consolidation of Medicaid Waiver Programs by Health Innovation Subcommittee, Pigman

- CS/HB 749 Adoption Benefits by Children, Families & Seniors Subcommittee, Combee
- CS/HB 763 Access to Health Care Practitioner Services by Health Quality Subcommittee, Grant, M.
- CS/HB 785 Stroke Centers by Health Quality Subcommittee, Magar
- HB 2077 Postdoctoral Research Program at Scripps Florida by Magar
- HB 2177 Love and Hope in Action-Shelter Kitchen Renovation by Magar
- HB 2405 State Veterans' Nursing Home Planning-Marion County by McClain
- HB 2431 Veterans' Home Program-City of Pembroke Pines by Jones
- HB 2539 The Arc Jacksonville - Transition to Community Employment by Cummings
- HB 2581 Healthcare Network of Southwest Florida's Integrated Behavioral Health Services Program by Donalds
- HB 2639 Charlotte Behavioral Health Care Community Action Team (CAT) - Charlotte County by Grant, M.
- HB 2641 Manatee County Opioid Addiction Recovery Peer Pilot Program by Gruters, Gonzalez
- HB 2741 The Miracle League of Miami Dade by Diaz, J.
- HB 2747 Our Pride Academy, Inc. by Diaz, J.
- HB 2773 Center for Independent Living Central Florida, Inc. - Central Florida Health and Safety for Seniors Pilot Project by Harrell
- HB 2783 Florida Baptist Children's Home - Brave Moms Program by Combee
- HB 2821 Florida Association of Infant Mental Health - Building the State's Infant Mental Health Workforce by Newton

- HB 2883 Miami Beach Community Health Center - Increased Access to Primary Health Care Services by Duran

- HB 2895 Protecting Young Hearts-Who We Play For Florida by Duran

- HB 2937 Crohn's & Colitis Foundation of America-University of Florida Research on Colitis Associated Colorectal Cancer by Berman

- HB 2975 City of Homestead - Efforts to Combat Sickle Cell Disease by Raschein

- HB 3027 ChildNet - Tech Care for Kids Mobile Child Welfare Applications by Jenne

- HB 3063 Meridian Behavioral Health by Watson, C.

- HB 3153 Henderson Behavioral Health New Crisis Stabilization Unit by Stark

- HB 3161 SalusCare - The REACH Institute, Training and Services to Providers of Behavior Health Services by Eagle

- HB 3253 CESC - Homelessness Services and Residential Support by Beshears

- HB 3259 New Hope Residential Substance Abuse and Mental Health (SAMH) Treatment Project by Nuñez

- HB 3283 Helping Hands - Services to At-Risk Youth by Hardemon

- HB 3299 Keys Area Health Education Center-Monroe County Children's Health Center by Raschein

- HB 3307 Veterans Villa Training Initiative by Daniels

- HB 3311 Lakeview Center - Children's Community Action Treatment Team for Santa Rosa County by Williamson

- HB 3351 Senior Smiles Pilot Program - Broward, Miami-Dade, and Palm Beach by Slosberg

- HB 3439 Agape Network - Integrated Care Team, Behavioral Health Services by Nuñez

- HB 3455 South Florida Behavioral Health Network - Involuntary Outpatient Services Demonstration Pilot by Diaz, J.

- HB 3471 Victory for Youth-Share Your Heart by Diaz, J.

- HB 3591 Lifestream Behavioral Center - Crisis Stabilization Units by Metz

- HB 3641 Southwest Florida Military Museum & Library by Eagle

- HB 3675 Family Preservation Services of Florida - Children's Community Action Treatment (CAT) of the Treasure Coast by Jones

- HB 3711 Disproportionate Share Hospital Allocation to Free Standing Children's Hospitals – Nemours Children's Hospital by Plasencia

- HB 3791 Flagler Hospital Sole Community Medicaid Rate Enhancement by Stevenson

- HB 3847 Bridgeway Center – Emergency Mobile Access Team by Ponder

- HB 3883 St. John Bosco Clinic by Avila

- HB 3897 Directions for Living - Baby Community Action Treatment (CAT) Team - Behavioral Health Services for Parents of Young Children by Latvala

- HB 4045 Starting Point Behavioral Healthcare – Integrated Care Team by Byrd

- HB 4079 Youth and Family Alternatives –Development of Affordable Housing for Persons with Developmental Disabilities by Burgess

- HB 4123 Citrus Health Network - Safe Haven for Homeless Youth by Richardson

- HB 4325 Osceola Mental Health - Children's Community Action Treatment-CAT Team by La Rosa

- HB 4335 The Transition House - Residential Recovery Services for Homeless Veterans by La Rosa

- HB 4349 Alachua County Organization for Rural Needs (ACORN) Clinic-Healthcare Safety Net for North Florida by Payne

- HB 4359 Here's Help - Health Education and Literacy Program (HELP) by Diaz, J.

- HB 4361 Southwest Social Services Programs, Inc. - Dr. Armando Badia Senior Center by Diaz, J.

- HB 4369 Camillus House Human Trafficking Recovery Program by Diaz, J

- HB 4371 Community Coalition Hot Meals Program by Diaz, J.

- HB 4383 PARC Florida - Transportation Services for the Developmentally Disabled by Diamond

- HB 4411 Hospital Outpatient Services Cancer Center Prospective Payment System Exemption by Grant, J.

- HB 4413 Hospital Inpatient Services Cancer Center Prospective Payment System Exemption by Grant, J.

IV. Closing Remarks/Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 23 Public Assistance
SPONSOR(S): Children, Families & Seniors Subcommittee, Eagle and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	12 Y, 2 N, As CS	Langston	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida's Temporary Cash Assistance (TCA) Program provides cash assistance to needy families with children that meet eligibility requirements. To be eligible for full-family TCA, applicants must participate in work activities unless they qualify for an exemption. The regional workforce boards support and monitor applicants' compliance with work activity requirements. The Department of Children and Families (DCF) may sanction TCA recipients who fail to meet work activity requirements through the withholding of cash assistance for a specified minimum time or until the participant complies, whichever is later. The sanctions are either full-family (where no members of the noncompliant recipient's family may receive TCA) or allow for child–only TCA (where any children under 16 may continue to receive TCA). In Florida, TCA and other social welfare benefits are placed on Electronic Benefits Transfer (EBT) cards. Currently, there is no fee charged in Florida for replacement EBT cards, although federal regulations allow the imposition of such fees under certain conditions.

HB 23 increases the penalties for the first three instances of noncompliance with the TCA work requirements to align with the food assistance program's sanctions and creates a fourth sanction. The bill:

- Increases the first sanction from 10 days to one month; this sanction remains full-family.
- Increases the second sanction from one month or until compliance, whichever is later, to three months or until compliance, whichever is later; and limits child-only TCA to the first three months of the sanction period.
- Increases the third sanction from three months or until compliance, whichever is later, to six months or until compliance, whichever is later; and limits child-only TCA to the first six months of the sanction period.
- Creates a fourth sanction of twelve months or until compliance, whichever is later, and that the individual must reapply to the program; and limits child-only TCA to the first twelve months of the sanction period.

The Department of Children and Families (DCF) must refer sanctioned participants to appropriate free and low-cost community services, including food banks. Additionally, the Department of Economic Opportunity, with DCF and CareerSource Florida, must work with the participant to develop strategies on how to overcome barriers to compliance with the TCA work requirements that the recipient faces. They must also inform the participant, in plain language, and have the participant agree to, in writing, what is expected of the applicant to continue to receive benefits, under what circumstances the applicant would be sanctioned, and potential penalties for noncompliance with work requirements, including how long benefits would not be available.

The bill also amends the Relative Caregiver program to prohibit payment of TCA to a noncustodial parent who lives with the relative who is caring for the noncustodial parent's child and receiving Relative Caregiver funding.

The bill requires EBT cardholders to pay a fee for the fifth and every subsequent EBT card requested within a 12-month span. The bill allows DCF to deduct the fee from the cardholder's benefits and provides for a waiver of the fee upon a showing of good cause, such as that the card malfunctioned or the fee would cause extreme financial hardship.

Additionally, the bill prohibits the use of EBT cards at medical marijuana treatment centers or dispensing organizations; cigar stores and stands, pipe stores, smoke shops and tobacco shops; and business establishments primarily engaged in the practice of body piercing, branding or tattooing.

The bill has a recurring, positive fiscal impact of $2,758,265 in savings from the reduction in TCA benefits while participants experience penalties for noncompliance, and $325,000 in fees recouped from EBT card replacements. The bill has a nonrecurring, negative fiscal impact of $952,360 to implement changes to the TCA program and EBT card system.

The bill contains a placeholder appropriation.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Temporary Assistance for Needy Families (TANF)

Under the federal welfare reform legislation of 1996, the Temporary Assistance for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, and the Emergency Assistance program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides states, territories, and tribes federal funds each year. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized in 2006 by the Deficit Reduction Act of 2005. States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.

Florida's Temporary Cash Assistance Program

The Temporary Cash Assistance (TCA) Program provides cash assistance to families with children under the age of 18 or under age 19[1] if full time secondary school students, that meet the technical, income, and asset requirements. The purpose of the TCA Program is to help families become self-supporting while allowing children to remain in their own homes. In November 2016, 12,517 adults and 65,855 children received TCA.[2]

Full-Family vs. Child-Only TCA

Florida law specifies two categories of families who are eligible for TCA: those families that are work-eligible and may receive TCA for the full-family, and those families who are eligible to receive child-only TCA. Within the full-family cases, the parent or parents are required to comply with work requirements to receive TCA for the parent(s) and child(ren). Additionally, there are two types of child-only TCA:

- Where the child has not been adjudicated dependent, but is living with a relative,[3] or still resides with his or her custodial parent, but that parent is not eligible to receive TCA;[4] and
- The Relative Caregiver Program, where the child has been adjudicated dependent and has been placed with relatives by the court. These relatives are eligible for a payment that is higher than the typical child-only TCA.

The majority of cash assistance benefits are provided to child-only cases, through the Relative Caregiver Program or to work-eligible cases where the adult is ineligible due to sanction for failure to meet TCA work requirements. In November 2016, 35,350 of the 47,204 families receiving TCA were child-only cases.[5] In November 2016, there were 11,854 families receiving TCA through full-family

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[1] Parents, children and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.
[2] Department of Children and Families, Monthly Flash Report Caseload Data: November 2016, http://eww.dcf.state.fl.us/ess/reports/docs/flash2005.xls (last visited January 30, 2017).
[3] Grandparents or other relatives receiving child-only payments are not subject to the TANF work requirement or the TANF time limit.
[4] Child-only families also include situations where a parent is receiving federal Supplemental Security Income (SSI) payments, situations where the parent is not a U.S. citizen and is ineligible TCA due to their immigration status, and situations where the parent has been sanctioned for noncompliance with work requirements.
[5] *Supra*, note 2.

cases containing an adult, 520 of which were two-parent families; these are the families who are subject to work requirements.[6]

Administration

Various state agencies and entities work together through a series of contracts or memorandums of understanding to administer the TCA Program.

- The Department of Children and Families (DCF) is the recipient of the federal TANF block grant. DCF monitors eligibility and disperses benefits.
- CareerSource Florida, Inc. is the state's workforce policy and investment board. CareerSource Florida has planning and oversight responsibilities for all workforce-related programs.
- The Department of Economic Opportunity (DEO) implements the policy created by CareerSource.[7] DEO submits financial and performance reports ensuring compliance with federal and state measures and provides training and technical assistance to Regional Workforce Boards.
- Regional Workforce Boards (RWBs) provide a coordinated and comprehensive delivery of local workforce services. The RWBs focus on strategic planning, policy development and oversight of the local workforce investment system within their respective areas, and contracting with one-stop career centers. The contracts with the RWBs are performance- and incentive- based.

Eligibility Determination

An applicant must meet all eligibility requirements to receive TCA benefits. The initial application for TANF is processed by DCF. The application may be submitted in person, online or through the mail.

DCF determines an applicant's eligibility. Additionally, to be eligible for full-family TCA, applicants must participate in work activities unless they qualify for an exemption. Exemptions from the work requirement are available for:

- An individual who receives benefits under the Supplemental Security Income program or the Social Security Disability Insurance program.
- An adult who is not defined as a work-eligible individual under federal law.
- A single parent of a child less than 3 months of age, except that the parent may be required to attend parenting classes or other activities to better prepare for raising a child.
- An individual who is exempt from the time period pursuant to s. 414.105, F.S.

If no exemptions from work requirements apply, DCF refers the applicant to DEO.[8] Upon referral, the participant must complete an in-take application and undergo assessment by RWB staff which includes:

- Identifying barriers to employment.
- Identifying the participant's skills that will translate into employment and training opportunities.
- Reviewing the participant's work history
- Identifying whether a participant needs alternative requirements due to domestic violence, substance abuse, medical problems, mental health issues, hidden disabilities, learning disabilities or other problems which prevent the participant from engaging in full-time employment or activities.

[6] Id.
[7] S. 445.007(13), F.S.
[8] This is an electronic referral through a system interface between DCF's computer system and DEO's computer system. Once the referral has been entered into the DEO system the information may be accessed by any of the RWBs or One-Stop Career Centers.

Once the assessment is complete, the staff member and participant create the Individual Responsibility Plan (IRP). The IRP includes:

- The participant's employment goal;
- The participant's assigned activities;
- Services provided through program partners, community agencies and the workforce system;
- The weekly number of hours the participant is expected to complete; and
- Completion dates and deadlines for particular activities.

DCF does not disperse any benefits to the participant until DEO or the RWB confirms that the participant has registered and attended orientation.

Work Requirement

Individuals receiving TCA who are not otherwise exempt from work activity requirements must participate in work activities for the maximum number of hours allowable under federal law.[9] The number of required work or activities hours is determined by calculating the value of the cash benefits and then dividing that number by the hourly minimum wage amount.

Federal law requires individuals to participate in work activities for at least:

- 20 hours per week, or attend a secondary school or the equivalent or participate in education directly related to employment if under the age of 20 and married or single head-of-household.
- 20 hours per week for single parents with a child under the age of six.
- 30 hours per week for all other single parents.
- 35 hours per week, combined, for two-parent families not receiving subsidized child care.
- 55 hours per week, combined, for two-parent families receiving subsidized child care.

Pursuant to federal rule[10] and state law,[11] the following activities may be used individually or in combination to satisfy the work requirements for a participant in the TCA program:

- Unsubsidized employment.
- Subsidized private sector employment.
- Subsidized public sector employment.
- On-the-job training.
- Community service programs.
- Work experience.
- Job search and job readiness assistance.
- Vocational educational training.
- Job skills training directly related to employment.
- Education directly related to employment.
- Attendance at school or course of study for graduate equivalency diploma.
- Providing child care services.[12]

RWBs currently have discretion to assign an applicant to a work activity, including job search, before receiving TCA. Some RWBs already require applicants to complete an initial job search as part of the application process.[13] Currently, Florida's TANF Work Verification Plan[14] requires participants to record

[9] S. 445.024(2), F.S.
[10] 45 C.F.R. § 261.30
[11] S. 445.024, F.S.
[12] S. 445.024(1)(a)-(l), F.S.
[13] Department of Children and Families, Agency Analysis of 2016 House Bill 563 (Nov. 20, 2015)(on file with Children, Families, and Seniors Subcommittee staff).

each on-site job contact and a representative of the employer or RWB provider staff to certify the validity of the log by signing each entry. If the applicant conducts a job search by phone or internet, the activity must be recorded on a job search report form and include detailed, specific information to allow follow-up and verification by the RWB provider staff.[15]

Sanctions for Noncompliance

RWBs can sanction TANF recipients who fail to comply with the work requirements by withholding cash assistance for a specified time, which lengthens with repeated lack of compliance. The participant's noncompliance can result in sanctions, as follows:

- First noncompliance - cash assistance is terminated for the full-family for a minimum of 10 days or until the individual complies.
- Second noncompliance - cash assistance is terminated for the full-family for one month or until the individual complies, whichever is later.
- Third noncompliance - cash assistance is terminated for the full-family for three months or until the individual complies, whichever is later.

In State Fiscal Year (SFY) 2015-16, the number of TCA families sanctioned for noncompliance with the work requirements breaks down as follows:

- 16,800 families were sanctioned for a first instance of non-compliance; 6,835, or 40.7 percent, of those families complied with work requirements to be reinstated in the program.[16]
- 4,455 families were sanctioned for a second instance of non-compliance; 2,087, or 46.8 percent, of those families complied with the work requirements to be reinstated in the program.[17]
- 2,409 families were sanctioned for a third instance of non-compliance; 1,007, or 41.8 percent, of those families complied with the work requirements to be reinstated in the program.[18]

For the second and subsequent instances of noncompliance, the TCA for the child or children in a family who are under age 16 may be continued (i.e. the case becomes a child-only case). Any such payments must be made through a protective payee and under no circumstances may temporary cash assistance or food assistance be paid to an individual who has not complied with program requirements. Of those families receiving second and third level sanctions, 1,836, or 26.7 percent, of those who regain eligibility after sanction do so via a child-only case.[19]

However, if a participant who was previously sanctioned fully complies with work activity requirements for at least six months, the participant must be reinstated as being in full compliance with program requirements for purpose of sanctions imposed under this section.[20] Once the participant has been reinstated, a subsequent instance of noncompliance would be treated as the first violation.

TCA Sanctions Compared to Supplemental Nutrition Assistance Program Sanctions

The Food Assistance Program, Supplemental Nutrition Assistance Program (SNAP), formerly called food stamps, also contains similar sanctions for failure to comply with its Employment and Training Program when receiving benefits. However, the SNAP sanctions are a longer duration. For the first

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[14] DEPARTMENT OF CHILDREN AND FAMILIES ECONOMIC SELF-SUFFICIENCY PROGRAM OFFICE, *Temporary Assistance for Needy Families State Plan Renewal October 1, 2014 – September 30, 2017,* Nov. 14, 2014, available at www.dcf.state.fl.us/programs/access/docs/TANF-Plan.pdf (last visited January 30, 2017).

[15] *Supra,* note 13 at 2.

[16] Email from Lindsey Zander, Legislative Specialist, Department of Children and Families, RE: HB 23 (Feb. 3, 2017) (On file with Children, Families, and Seniors Subcommittee staff).

[17] Id.

[18] Id.

[19] Id.

[20] S. 414.065(1), F.S.

instance of noncompliance, food assistance benefits are terminated for one month or until compliance, whichever is later; for the second instance, food assistance benefits are terminated for three months or until compliance, whichever is later; and for the third instance, food assistance benefits are terminated for six months or until compliance, whichever is longer.[21]

Relative Caregiver Program

The Relative Caregiver Program provides TCA to individuals who meet eligibility rules and have custody of a relative child under age 18 who has been court-ordered dependent by a Florida court and placed in their home by a DCF Child Welfare/Community Based Care contracted provider.[22] The intent of the Relative Caregiver Program is to provide relative caregivers who could not otherwise afford to take the child into their homes a means to avoid exposing the child to the trauma of shelter or foster care.

The Relative Caregiver Program provides one type of child-only TCA. Payments are based on the child's age and any countable income.[23] DCF ceases to provide child-only Relative Caregiver Program benefits when the parent or step-parent resides in the home with the relative caregiver and the child. DCF terminates the benefits in this situation based on the requirement in s. 414.095(2)(a)5., F.S., that parents who live with their minor children to be included in the eligibility determination and households containing a parent are considered work-eligible households. Through rule 65C-28.008(2)(d), F.A.C., DCF terminates payments through the Relative Caregiver Program if the parent is in the home for 30 consecutive days.[24] However, at least one court has ruled that caregivers may continue to receive the Relative Caregiver Program benefits while the parent resides in the home, because the prohibition against the parent residing in the home is not in statute and DCF rules cannot be used to establish an eligibility guideline not included in the statute. Court orders in such cases result in DCF being required to make disallowed TANF expenditures.

Electronic Benefits Transfer (EBT) Card Program

Electronic Benefits Transfer (EBT) is an electronic system that allows a recipient to authorize transfer of their government benefits, including from the SNAP and TCA programs, to a retailer account to pay for products received.[25] The EBT card program is administered on the federal level by the Food and Nutrition Service (FNS) within the United States Department of Agriculture and at the state level by DCF.

In Florida, benefits are deposited into a TCA or SNAP account each month; the benefits in the TCA or SNAP account are accessed using the Florida EBT Automated Community Connection to Economic Self Sufficiency (ACCESS) card.[26] Even though the EBT card is issued in the name of an applicant, any eligible member of the household is allowed to use the EBT card.[27] Additionally, recipients may designate an authorized representative as a secondary cardholder who can receive an EBT card and access the food assistance account. Authorized representatives are often someone responsible for caring for the recipient. The ACCESS Florida system allows recipients to designate one authorized representative per household.

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[21] Rule 65A-1.605(3), F.A.C.
[22] S. 39.5085(2), F.S.
[23] Rule 65C-28.008(2)(g), F.A.C.
[24] However, a relative may receive the Relative Caregiver Program payment for a minor parent who is in his or her care, as well as for that minor parent's child, if both children have been adjudicated dependent and meet all other eligibility requirements.
[25] U.S. DEPARTMENT OF AGRICULTURE, FOOD AND NUTRITION SERVICES, *EBT: General Electronic Benefit Transfer (EBT) Information*, http://www.fns.usda.gov/ebt/general-electronic-benefit-transfer-ebt-information (last visited January 31, 2017).
[26] DEPARTMENT OF CHILDREN AND FAMILIES, *Welcome to EBT,* http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/welcome-ebt (last visited January 31, 2017).
[27] 7 C.F.R. § 273.2(n)(3).

Prohibited Usage

The Middle Class Tax Relief and Job Creation Act of 2012 required states receiving TANF to create policies and practices as necessary to prevent assistance provided under the program from being used in any EBT transaction in the following establishments:

- Any liquor store;
- Any casino, gambling casino, or gaming establishment; or
- Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. [28]

In 2013, Florida enacted legislation[29] that prohibits EBT cards from being accepted at the following locations or for the following activities:

- The purchase of an alcoholic beverage as defined in s. 561.01, F.S., and sold pursuant to the Florida Beverage Law.
- An adult entertainment establishment, as defined in s. 847.001, F.S.;
- A pari-mutuel facility, as defined in s. 550.02, F.S.;
- A slot machine facility, as defined in s. 551.102, F.S.;
- A commercial bingo facility that operates outside the provisions of s. 849.0931, F.S.; and
- A casino, gaming facility, or Internet café, including gaming activities authorized under part II of chapter 285.[30]

Replacement of EBT Cards

When a recipient loses his or her EBT card, he or she must call the EBT vendor's customer service telephone number to request a replacement EBT card.[31] The vendor then deactivates the card, and sends the household a new card.[32] Federal regulations allow recipients to request an unlimited number of replacement EBT cards.[33] While states cannot limit the number of replacement cards, frequent requests for replacement cards can be an indicator of EBT card fraud, such as trafficking, which occurs when an EBT card containing benefits is exchanged for cash. FNS and DCF consider multiple replacement cards a preliminary indicator of trafficking.

FNS aims to preserve food assistance access for vulnerable populations (e.g., mentally ill and homeless people) who are at risk of losing their cards but who are not committing fraud,[34] while preventing others from trafficking and replacing their EBT cards. In the interest of preventing fraud, FNS regulations require states to monitor all client requests for EBT card replacements and send a notice, upon the fourth request in a 12-month period, alerting the household that their account is being monitored for potential suspicious activity.[35]

In Fiscal Year 2014-15, DCF sent 13,967 letters to households that had requested four or more cards.[36] The letter informs the recipient that the card does not need to be replaced each month and that it is

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[28] P.L. 112-96. Section 4004.
[29] S. 1, chapter 2013-88, Laws of Florida.
[30] S. 402.82(4), F.S.
[31] The Florida Legislature's Office of Program Policy Analysis & Government Accountability, *Supplemental Nutrition Assistance Program: DCF Has Mechanisms in Place to Facilitate Eligibility, Verify Participant Identity, and Monitor Benefit Use*, Dec. 3, 2015, p. 8 (research memorandum on file with Children, Families, and Seniors Subcommittee staff).
[32] Id.
[33] 7 C.F.R. § 276.4
[34] 7 C.F.R. § 274.6(b)(5)(iii).
[35] 7 C.F.R. § 274.6(b)(6); in Florida, after the EBT vendor provides a fourth replacement card to a household within a 12-month span, DCF sends a letter to the household.
[36] *Supra*, note 31.

important to keep track of the card.[37] The letter also informs the recipient that this number of replacement requests is not normal and that the household's EBT behavior is being monitored.[38] Additionally, in Fiscal Year 2014-15, less than one-third of the households who requested four cards (4,653 households) requested yet another replacement card after receiving the letter, and the DCF Office of Public Benefits Integrity referred these cases to the Department of Financial Services Division of Public Assistance Fraud (DPAF) for potential fraud investigation.[39]

Federal regulations allow states to charge recipients for the cost to replace an excessive[40] number of cards. FNS allows states to charge for the cost of the EBT card after four replaced cards. Under DCF's EBT contract, the vendor reports that replacements costs $3.50 per card.[41] A number of other states that charge for replacement cards. Those states charge between $2.00 to $5.00[42] per replacement card with some exceptions for good cause or financial hardship.

Effect of the Bill

Temporary Cash Assistance

Sanctions for Noncompliance

HB 23 increases the sanctions for TCA recipients who are subjected to the work requirements for the first three instances of noncompliance and creates a sanction for the fourth instance of noncompliance. The bill amends s. 414.065(1) and (2), F.S., to:

- Increase the first sanction from 10 days to one month; this sanction remains full-family.
- Increase the second sanction from one month or until compliance, whichever is later, to three months or until compliance, whichever is later; and provides that child-only TCA, for children in the family under 16 years old, is only available for the first three months of the sanction period even if participant takes longer to comply.
- Increase the third sanction from three months or until compliance, whichever is later, to six months or until compliance, whichever is later; and provides that child-only TCA, for children in the family under 16 years old, is only available for the first six months of the sanction period even if participant takes longer to comply.
- Create a fourth sanction of twelve months or until compliance, whichever is later, and that the individual must reapply to the program to resume receiving benefits; and provides that child-only TCA, for children in the family under 16 years old, is only available for the first twelve months of the sanction period even if participant takes longer to comply.

The bill aligns the sanctions for the first through third occurrences of noncompliance with TCA work requirements with the sanctions for noncompliance with the SNAP program's Employment and Training Program. When a participant is sanctioned, DCF must refer him or her to appropriate free and low-cost community services, including food banks. Additionally, the bill clarifies that participants may comply with the work activity requirements before the end of the minimum penalty period.

[37] Id.
[38] Id.
[39] Id.
[40] Defined by federal regulation as in excess of four cards within a 12-month span.
[41] *Supra*, note 31.
[42] By way of example, Louisiana and Maryland charge $2.00, New Mexico charges $2.50, and Massachusetts charges $5.00.

Work Plan

The bill requires that, prior to receipt of TCA, DEO, DCF, or CareerSource must inform the participant, in plain language, and have the participant agree to, in writing:

- What is expected of the applicant to continue to receive benefits;
- Under what circumstances the applicant would be sanctioned; and
- Potential penalties for noncompliance with work requirements, including how long benefits would not be available to the applicant.

The bill also requires that, prior to receipt of TCA, DEO, DCF, or CareerSource must work with the participant to develop strategies on how to overcome barriers to compliance with the TCA work requirements that the recipient faces.

Relative Caregiver Program

The bill amends s. 39.5085, F.S., to clarify that a caregiver may not receive payment through the Relative Caregiver Program if the parent or step-parent resides in the home with his or her child. Section 414.095(2)(a)5., F.S., requires parents and step-parents who live with their minor children to be included for eligibility determination and TCA regulations that define households containing a parent as a "work eligible" household. This strengthens DCF's policy position and protects the state from potential federal disallowance in the TANF program.[43]

EBT Cards

Prohibited Usage

The bill expands the locations where EBT cards may not be used to include:

- Medical marijuana treatment centers or dispensing organizations;
- Cigar stores and stands, pipe stores, smoke shops and tobacco shops; and
- Business establishments primarily engaged in the practice of body piercing, branding or tattooing.

Replacement Fee

The bill requires EBT cardholders to pay a fee for the fifth and all subsequent EBT replacement cards requested within a 12-month span. DCF currently sends a letter with the fourth replacement card informing the cardholder that his or her case is being monitored for potential trafficking activity. By charging the fee beginning with the fifth card, DCF may inform the cardholder in the letter that it sends with the fourth replacement card about replacement fees for subsequent new cards.

The bill allows DCF to deduct the fee from the cardholder's benefits and provides for a waiver of the fee upon a showing of good cause, such as that the card malfunctioned or the fee would cause extreme financial hardship.

B. SECTION DIRECTORY:

Section 1: Amends s. 414.069, F.S., relating to noncompliance with work requirements.
Section 2: Amends s. 445.024, F.S., relating to work requirements.

[43] Department of Children and Families, Agency Bill Analysis for 2017 House Bill 0023, p. 4 (Nov. 30, 2016) (On file with Children, Families, and Seniors Subcommittee Staff).

Section 3: Amends s. 402.82, F.S., relating to electronic benefits transfer program.
Section 4: Amends s. 39.5085, F.S., relating to the Relative Caregiver Program.
Section 5: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None. See fiscal comments.

2. Expenditures:

   The bill increases the length of time during which TCA recipients are ineligible for benefits when not meeting the program's work requirements. The bill expands three existing penalty periods and creates a new fourth period. It is expected that these provisions will decrease recurring state expenditures for temporary cash assistance in the amount of $2,758,265.[44]

   In addition to the enhanced penalties, the bill imposes a fee for a fifth, and subsequent, replacement EBT card(s) within a 12-month period and provides such fee may be deducted from the participant's TCA benefits. One-time programming modifications to DCF's public benefits disbursement system are expected to cost $952,360.[45] The bill contains an appropriations placeholder for an unspecified amount.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

DCF may charge the costs of replacement cards against an EBT cardholder's benefits. The cardholder's benefits will be reduced by the cost to replace his or her EBT card. Assuming a replacement cost of $5.00 per card, the estimated card replacement fees recouped could approach $325,000 based replacing 65,000 cards.[46] Fee collections could diminish as the new process affects customer behaviors.[47]

D. FISCAL COMMENTS:

The bill contains a placeholder appropriation.

[44] Id. at p. 5.
[45] Id. at p. 7.
[46] Id.
[47] Id.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 9, 2017, the Children, Families, and Seniors Subcommittee adopted an amendment that prohibits the use of EBT cards at:

- Medical marijuana treatment centers or dispensing organizations;
- Cigar stores and stands, pipe stores, smoke shops and tobacco shops; and
- Business establishments primarily engaged in the practice of body piercing, branding or tattooing.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

A bill to be entitled

An act relating to public assistance; amending s. 414.065, F.S.; revising penalties for noncompliance with work requirements for temporary cash assistance; limiting the receipt of child-only benefits during periods of noncompliance with work requirements; providing applicability of work requirements before expiration of the minimum penalty period; requiring the Department of Children and Families to refer sanctioned participants to appropriate free and low-cost community services, including food banks; amending s. 445.024, F.S.; requiring the Department of Economic Opportunity, in cooperation with CareerSource Florida, Inc., and the Department of Children and Families, to develop and implement a work plan agreement for participants in the temporary cash assistance program; requiring the plan to identify expectations, sanctions, and penalties for noncompliance with work requirements; amending s. 402.82, F.S.; prohibiting the use of an electronic benefits transfer card at specified locations; requiring the Department of Children and Families to impose a replacement fee for electronic benefits transfer cards under certain circumstances; amending s. 39.5085, F.S.; revising eligibility guidelines for

the Relative Caregiver Program with respect to relative and nonrelative caregivers; providing an appropriation; providing an effective date.

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

Section 1. Subsection (1) and paragraph (a) of subsection (2) of section 414.065, Florida Statutes, are amended to read:

414.065 Noncompliance with work requirements.—

(1) PENALTIES FOR NONPARTICIPATION IN WORK REQUIREMENTS AND FAILURE TO COMPLY WITH ALTERNATIVE REQUIREMENT PLANS.—The department shall establish procedures for administering penalties for nonparticipation in work requirements and failure to comply with the alternative requirement plan. If an individual in a family receiving temporary cash assistance fails to engage in work activities required in accordance with s. 445.024, the following penalties shall apply. Prior to the imposition of a sanction, the participant shall be notified orally or in writing that the participant is subject to sanction and that action will be taken to impose the sanction unless the participant complies with the work activity requirements. The participant shall be counseled as to the consequences of noncompliance and, if appropriate, shall be referred for services that could assist the participant to fully comply with program requirements. If the participant has good cause for

noncompliance or demonstrates satisfactory compliance, the sanction may ~~shall~~ not be imposed. If the participant has subsequently obtained employment, the participant shall be counseled regarding the transitional benefits that may be available and provided information about how to access such benefits. The department shall administer sanctions related to food assistance consistent with federal regulations.

(a)1. First noncompliance: temporary cash assistance shall be terminated for the family for a minimum of 1 month ~~10 days~~ or until the individual who failed to comply does so, whichever is later. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

2. Second noncompliance:

a. Temporary cash assistance shall be terminated for the family for 3 months ~~1 month~~ or until the individual who failed to comply does so, whichever is later. The individual shall be required to comply with the required work activity upon completion of the 3-month penalty period before reinstatement of temporary cash assistance. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

b. Upon the second occurrence of noncompliance, temporary cash assistance for the child or children in a family who are

under age 16 may be continued for the first 3 months of the penalty period through a protective payee as specified in subsection (2).

3. Third noncompliance:

a. Temporary cash assistance shall be terminated for the family for 6 ~~3~~ months or until the individual who failed to comply does so, whichever is later. The individual shall be required to comply with the required work activity upon completion of the 6-month ~~3-month~~ penalty period~~,~~ before reinstatement of temporary cash assistance. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

b. Upon the third occurrence of noncompliance, temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first 6 months of the penalty period through a protective payee as specified in subsection (2).

4. Fourth noncompliance:

a. Temporary cash assistance shall be terminated for the family for 12 months or until the individual who failed to comply does so, whichever is later. The individual shall be required to comply with the required work activity upon completion of the 12-month penalty period and reapply before reinstatement of temporary cash assistance. Upon meeting this

requirement, temporary cash assistance shall be reinstated to the first day of the month following the penalty period.

b. Upon the fourth occurrence of noncompliance, temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first 12 months of the penalty period through a protective payee as specified in subsection (2).

5. The sanctions imposed under subparagraphs 1.-4. do not prohibit a participant from complying with the work activity requirements during the penalty periods imposed by this paragraph.

(b) If a participant receiving temporary cash assistance who is otherwise exempted from noncompliance penalties fails to comply with the alternative requirement plan required in accordance with this section, the penalties provided in paragraph (a) shall apply.

(c) When a participant is sanctioned for noncompliance with this section, the department shall refer the participant to appropriate free and low-cost community services, including food banks.

If a participant fully complies with work activity requirements for at least 6 months, the participant shall be reinstated as being in full compliance with program requirements for purpose of sanctions imposed under this section.

(2) CONTINUATION OF TEMPORARY CASH ASSISTANCE FOR CHILDREN; PROTECTIVE PAYEES.—

(a) Upon the second or subsequent ~~third~~ occurrence of noncompliance, subject to the limitations in paragraph (1)(a), temporary cash assistance and food assistance for the child or children in a family who are under age 16 may be continued. Any such payments must be made through a protective payee or, in the case of food assistance, through an authorized representative. Under no circumstances shall temporary cash assistance or food assistance be paid to an individual who has failed to comply with program requirements.

Section 2. Subsections (3) through (7) of section 445.024, Florida Statutes, are renumbered as subsections (4) through (8), respectively, and a new subsection (3) is added to that section, to read:

445.024 Work requirements.—

(3) WORK PLAN AGREEMENT.—For each individual who is not otherwise exempt from work activity requirements, but before a participant may receive temporary cash assistance, the Department of Economic Opportunity, in cooperation with CareerSource Florida, Inc., and the Department of Children and Families, must:

(a) Inform the participant, in plain language, and require the participant to assent to, in writing:

1. What is expected of the participant to continue to

receive temporary cash assistance benefits.

2. Under what circumstances the participant would be sanctioned for noncompliance.

3. Potential penalties for noncompliance with work requirements in s. 414.065, including how long benefits would not be available to the participant.

(b) Work with the participant to develop strategies to assist the participant in overcoming obstacles to compliance with the work activity requirements.

Section 3. Paragraphs (g), (h), and (i) are added to subsection (4) of section 402.82, Florida Statutes, and subsection (5) is added to that section, to read:

402.82 Electronic benefits transfer program.—

(4) Use or acceptance of an electronic benefits transfer card is prohibited at the following locations or for the following activities:

(g) A medical marijuana treatment center or dispensing organization.

(h) A cigar store or stand, pipe store, smoke shop, or tobacco shop.

(i) A body piercing salon as defined in s. 381.0075(2)(b), a tattoo establishment as defined in s. 381.00771, or a business establishment primarily engaged in the practice of branding.

(5) The department shall impose a fee for the fifth and each subsequent request for a replacement electronic benefits

transfer card that a participant requests within a 12-month period. The fee must be equal to the cost to replace the electronic benefits transfer card. The fee may be deducted from the participant's benefits. The department may waive the replacement fee upon a showing of good cause, such as the malfunction of the card or extreme financial hardship.

Section 4. Paragraph (a) of subsection (1) and paragraph (a) of subsection (2) of section 39.5085, Florida Statutes, are amended to read:

39.5085 Relative Caregiver Program.—

(1) It is the intent of the Legislature in enacting this section to:

(a) Provide for the establishment of procedures and protocols that serve to advance the continued safety of children by acknowledging the valued resource uniquely available through grandparents, relatives of children, and specified nonrelatives of children pursuant to sub-subparagraph (2)(a)1.c. ~~subparagraph (2)(a)3.~~

(2)(a) The Department of Children and Families shall establish, ~~and~~ operate, and implement the Relative Caregiver Program ~~pursuant to eligibility guidelines established in this section as further implemented~~ by rule of the department.

1. The Relative Caregiver Program shall, within the limits of available funding, provide financial assistance to:

a.~~1.~~ Relatives who are within the fifth degree by blood or

marriage to the parent or stepparent of a child and who are caring full-time for that dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.

b.~~2.~~ Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child, and a dependent half-brother or half-sister of that dependent child, in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.

c.~~3.~~ Nonrelatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the nonrelative caregiver under this chapter. The court must find that a proposed placement under this subparagraph is in the best interest of the child.

2. The relative or nonrelative caregiver may not receive a Relative Caregiver Program payment if the parent or stepparent of the child resides in the home. However, a relative or nonrelative may receive the payment for a minor parent who is in his or her care and for the minor parent's child, if both the minor parent and the child have been adjudicated dependent and

meet all other eligibility requirements. If the caregiver is currently receiving the payment, the payment must be terminated no later than the first day of the following month after the parent or stepparent moves into the home. Before the payment is terminated, the caregiver must be given 10 days' notice of adverse action.

The placement may be court-ordered temporary legal custody to the relative or nonrelative under protective supervision of the department pursuant to s. 39.521(1)(b)3., or court-ordered placement in the home of a relative or nonrelative as a permanency option under s. 39.6221 or s. 39.6231 or under former s. 39.622 if the placement was made before July 1, 2006. The Relative Caregiver Program shall offer financial assistance to caregivers who would be unable to serve in that capacity without the caregiver payment because of financial burden, thus exposing the child to the trauma of placement in a shelter or in foster care.

Section 5. For fiscal year 2017-2018, the sum of $XXX,XXX in nonrecurring funds from the Federal Grants Trust Fund is appropriated to the Department of Children and Families for the purpose of performing the technology modifications necessary to implement changes to the disbursement of temporary cash assistance benefits and the replacement of electronic benefits transfer cards pursuant to this act.

Section 6. This act shall take effect July 1, 2017.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Eagle offered the following:

Amendment

Remove line 244 and insert:

Section 5. For fiscal year 2017-2018, the sum of $952,360

Amendment No.2

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Eagle offered the following:

Amendment

Remove lines 58-63 and insert:

(a)1. First noncompliance:

a. Temporary cash assistance shall be terminated for the family for a minimum of 1 month ~~10 days~~ or until the individual who failed to comply does so, whichever is later. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

b. Upon the first occurrence of noncompliance, temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first month of the penalty

period through a protective payee as specified in subsection (2).

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 229 Programs For Impaired Health Care Practitioners
SPONSOR(S): Health Quality Subcommittee; Byrd
TIED BILLS: **IDEN./SIM. BILLS:** SB 876

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The impaired practitioner program was established within the Department of Health (DOH), by s. 456.076, F.S., to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or of a mental or physical condition, which could affect the ability to practice with skill and safety.

Currently, DOH must contract with at least one entity to serve as a consultant for the impaired practitioner program. The consultant receives referrals from DOH, a regulatory board or health care entities, as well as self-referrals. Upon receipt of a referral, the consultant coordinates an evaluation of the practitioner. After the evaluation, a treatment plan, if needed, is developed, and as the practitioner undergoes treatment, the consultant monitors the progress. The consultant advises the appropriate board, or DOH if there is no board, when a practitioner successfully completed treatment and is able to practice safely. However, if a practitioner fails to complete treatment, the consultant notifies the appropriate board or DOH to initiate disciplinary proceedings, as warranted. Consultants have sovereign immunity currently.

HB 229 authorizes, rather than requires, DOH to retain one or more consultants to operate its impaired practitioner program. Under the bill, the contract with the consultant must require the consultant to accept referrals of practitioners who have or are suspected of having an impairment; arrange the evaluation and treatment of such practitioners, and monitor their progress and status to determine if and when they are able to safely to return to practice. The bill prohibits the consultant from providing evaluation and treatment services. Under the bill, a practitioner found to have an impairment may be accepted into the impaired practitioner program, and must enter into a participant contract which defines the planned or recommended treatment.

The bill requires DOH or licensure boards, rather than probable cause panels, to oversee matters involving impaired practitioners. As with current law, if a participant fails or is terminated from the impaired practitioner program, a consultant must notify DOH for disciplinary proceedings. If the consultant concludes that a practitioner's impairment constitutes an immediate, serious danger to public health, the consultant must notify DOH, rather than the Surgeon General.

Current law requires licensees to report violations of the core licensure statute (ch. 456, F.S.) and individual practice acts, the bill creates an exception that allows licensees to report individuals having an impairment or suspected of having an impairment to the consultant, rather than DOH.

The bill retains sovereign immunity, but also grants the consultant protection from any civil liability related to its actions under the impaired practitioner program. The bill retains the responsibility of the Department of Financial Services to provide a defense for any claim, suit, action, or proceeding brought against the consultant's directors and agents. The bill also protects a consultant, or an employee or agent of the consultant from liability for information it provides to a medical review committee.

The bill repeals the authority of a regulatory board, or DOH if there no board, to adopt rules relating to the impaired practitioner program. Currently, the rules adopted under this section provide definitions of terms and designates the entities authorized as consultants.

The bill may have an indeterminate, insignificant negative fiscal impact on the Department of Financial Services and no fiscal impact on local governments.

The bill provides the act is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medical Quality Assurance

The Department of Health (DOH) is created under the authority of s. 20.43, F.S., which outlines the composition of the agency structure to include the Division of Medical Quality Assurance (MQA). MQA is statutorily responsible for the following boards and professions established within the division:

- The Board of Acupuncture, created under chapter 457.
- The Board of Medicine, created under chapter 458.
- The Board of Osteopathic Medicine, created under chapter 459.
- The Board of Chiropractic Medicine, created under chapter 460.
- The Board of Podiatric Medicine, created under chapter 461.
- Naturopathy, as provided under chapter 462.
- The Board of Optometry, created under chapter 463.
- The Board of Nursing, created under part I of chapter 464.
- Nursing assistants, as provided under part II of chapter 464.
- The Board of Pharmacy, created under chapter 465.
- The Board of Dentistry, created under chapter 466.
- Midwifery, as provided under chapter 467.
- The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
- The Board of Nursing Home Administrators, created under part II of chapter 468.
- The Board of Occupational Therapy, created under part III of chapter 468.
- Respiratory therapy, as provided under part V of chapter 468.
- Dietetics and nutrition practice, as provided under part X of chapter 468.
- The Board of Athletic Training, created under part XIII of chapter 468.
- The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.
- Electrolysis, as provided under chapter 478.
- The Board of Massage Therapy, created under chapter 480.
- The Board of Clinical Laboratory Personnel, created under part III of chapter 483.
- Medical physicists, as provided under part IV of chapter 483.
- The Board of Opticianry, created under part I of chapter 484.
- The Board of Hearing Aid Specialists, created under part II of chapter 484.
- The Board of Physical Therapy Practice, created under chapter 486.
- The Board of Psychology, created under chapter 490.
- School psychologists, as provided under chapter 490.
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.
- Emergency medical technicians and paramedics, as provided under part III of chapter 401.

DOH regulates most health care professions.[1] Each profession is governed by an individual practice act and by ch. 456, F.S., which contains core licensure provisions that apply uniformly across all individual practice acts for health care practitioners[2].

[1] The Department of Business and Professional Regulation regulates veterinarians pursuant to ch. 474, F.S.

[2] Section 456.001(4), defines "health care practitioner" as any person licensed under: ch. 457, F.S., (acupuncture); ch. 458, F.S., (medical practice); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathy); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry, dental hygiene, and dental laboratories); ch. 467, F.S., (midwifery); parts I, II, III, V, X, XIII, and XIV of ch. 468, F.S., (speech-language

Impaired Practitioner Treatment Program

The impaired practitioner treatment program was created in s. 456.076, F.S., to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[3] For a profession that does not have a program established within its individual practice act, the DOH is required to designate an approved program by rule.[4] DOH has designated by rule that an approved impaired practitioner program is one that is designated by DOH through contract with a consultant to initiate intervention, recommend evaluation, and refer impaired practitioners to treatment providers and monitor progress of impaired practitioners. The impaired practitioner program may not provide medical services.[5] The terms "impaired practitioner program" and "consultant" appear to be used interchangeably.

DOH must retain at least one impaired practitioner consultant[6] who is licensed under the jurisdiction of MQA and who is a licensed physician or nurse; or an entity that employs a medical director who is a licensed physician, or an executive director who is a licensed nurse.[7] DOH currently contracts with the Professionals Resource Network (PRN) and the Intervention Project for Nurses (IPN) to provide approved treatment programs[8] for impaired practitioners.[9] PRN performs evaluation, treatment referrals, and monitoring for medical doctors and all allied health professions, except nurses and certified nursing assistants, which are served by IPN.[10]

A consultant may also to enter into a contract with a school or program to provide services to students preparing for a licensure as a health care practitioner or a veterinarian who may be impaired as a result of the misuse or abuse of alcohol or drugs, or both or due to a mental or physical condition.[11] DOH is not responsible for paying costs of care by an approved treatment program or the services provided by the consultant for students. Additionally, a school that is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant or for any disciplinary action that adversely affects the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provide by a consultant.[12]

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pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrolysis); ch. 480, F.S., (massage therapy); parts III and IV of ch. 483, F.S., (clinical laboratory personnel or medical physicists); ch. 484, F.S., (dispensing of optical devices and hearing aids); ch. 486, F.S., (physical therapy practice); ch. 490, F.S., (psychological services); and ch. 491, F.S. (clinical, counseling, and psychotherapy services).

[3] Section 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.

[4] Section 456.076(1), F.S.

[5] Rule 64B31-10.001(1)(a), F.A.C.

[6] Rule 64B31-10.001(1)(b), F.A.C., provides that a consultant operate an approved impaired practitioner program which receives allegations of licensee impairment, personally intervene or arrange intervention with licensees, refer licensees to approved treatment programs or treatment providers, evaluate treatment progress, and monitor continued care provided by approved programs and providers.

[7] Section 456.076(2), F.S.

[8] A treatment program is approved by a designated impaired practitioner program and must be a nationally accredited or state licensed residential, intensive outpatient, partial hospital, or other program with a multidisciplinary team approach with individual treatment providers treating licensees depending on the licensee's individual diagnosis and treatment plan that has been approved by an approved practitioner program. A treatment provider is approved by a designated impaired practitioner program and must be a state licensed or nationally certified individual with experience treating specific types of impairment. 64B31-10.001(1)(c), F.A.C.

[9] DOH, Board of Medicine, *Help Center: Does the Department Have Assistance Programs for Impaired Health Care Professionals*, http://flboardofmedicine.gov/help-center/does-the-department-have-assistance-programs-for-impaired-health-care-professionals/ (last visited Jan. 11, 2016).

[10] DOH, *2017 Agency Legislative Bill Analysis: House Bill 229*, on file with the Health Quality Subcommittee.

[11] Section 456.076(2)(c)2., F.S.

[12] Section 456.076(2)(d), F.S.

Operation of the Program

When DOH receives a legally sufficient complaint[13] alleging that a licensed practitioner is impaired and no other complaints exist against the practitioner, the complaint is forwarded to the consultant, who assists DOH in determining if the practitioner is, in fact, impaired. In addition to assisting DOH in determining the existence of an impairment, the consultant also facilitates and monitors progress in the treatment of the impairment.

Impairment is not grounds for discipline, if the probable cause panel[14] of the appropriate board, or the department when there is no board, finds that the licensee:

- Acknowledges the impairment;
- Voluntarily enrolls in an appropriate, approved treatment program;
- Voluntarily withdraws from practice or limits his or her scope of practice, as required by the consultant, until the licensee has successfully completed an approved treatment program; and
- Authorizes the release of medical records, including all records of evaluations, diagnoses, and treatment, to the consultant.[15]

An impaired practitioner may voluntarily withdraw from practice and seek treatment from a provider approved by DOH without a complaint being filed. In such situations, DOH and the applicable board are not involved in the case.

After an evaluation is completed, the evaluator will submit a report to the consultant advising whether the practitioner is in fact impaired and recommending treatment or that the practitioner is not impaired. The impaired practitioners are referred to DOH-approved treatment providers or treatment programs.[16] Although the impaired practitioner is not responsible for paying for the services of the consultant, the impaired practitioner must pay for his or her treatment.

The consultant evaluates the treatment progress of an impaired practitioner and monitors the continued care provided by treatment programs.[17] Consultants do not provide medical treatment, nor do they have the authority to render decisions relating to licensure of a particular practitioner. However, the consultant is required to make recommendations to DOH regarding a practitioner patient's ability to practice.[18]

If, in the opinion of the consultant, the health care practitioner has not made satisfactory progress in a treatment program, the consultant must disclose all information regarding the licensee's impairment and participation in a treatment program in its possession to DOH. Such disclosure constitutes a complaint. If the consultant concludes that a health care practitioner's impairment constitutes an immediate danger to the public health, safety, or welfare, the Surgeon General must be notified.[19] DOH may then take any disciplinary action against the license as authorized under law, including issuing an emergency order restricting or suspending the license.[20]

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[13] A complaint is legally sufficient if it contains ultimate facts that show the occurrence of a violation of a practice act, ch. 456, F.S., or a rule adopted by the DOH or a board. Section 456.073(1), F.S.

[14] A probable cause panel is a panel designated by rule of each regulatory board that is composed of at least two members, including at least one current board member, that review investigative information related to a complaint and determine, based on that information, whether probable cause exists to believe that a health care practitioner violated statutes governing the practice of the licensee's profession. If probable cause exists, the probable cause panel will direct DOH to file a formal complaint against the licensee. (s. 456.073(4), F.S.)

[15] Section 456.076(4), F.S.

[16] *Supra* note 10.

[17] Rule 64B31-10.001, F.A.C.

[18] Section 456.076(6), F.S.

[19] Section 456.074(7), F.S.

[20] *Supra* note 10.

As of January 2017, there were approximately 928 practitioners enrolled in the PRN program,[21] and IPN was providing services to 1,216 individuals.[22]

Consultant Sovereign Immunity

Sovereign Immunity

The legal doctrine of sovereign immunity prevents a government from being sued in its own courts without its consent.[23] According to United States Supreme Court Justice Oliver Wendell Holmes, citing the noted 17th century Hobbes work, *Leviathan*, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends."[24] State governments in the United States, as sovereigns, inherently possess sovereign immunity.[25]

Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state[26] will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.[27]

When an officer, employee, or agency of the state is sued, the state steps in as the party litigant and defends against the claim. The recovery by any one person is limited to $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000.[28] The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature.[29]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[30] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity: [31]

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.

The Court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship.[32] The facts of the case demonstrated the state's control over the independent contractor physicians and, therefore, the Court held that an agency relationship existed.[33]

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[21] PRN, "PRN Monthly Report for January 2017," (February 9, 2017), on file with the Health Quality Subcommittee.
[22] IPN, "January 2017 Monthly Report," (February 2, 2017), on file with the Health Quality Subcommittee.
[23] Black's Law Dictionary, 3rd Pocket Edition, 2006.
[24] *Kawananakoa v Polyblank*, 205 U.S. 349, 353 (1907).
[25] *See, e.g.,* Fla. Jur. 2d, Government Tort Liability, Sec. 1.
[26] The statutes define state agencies or subdivisions to include executive departments, the legislature, the judicial branch, and independent establishments of the state, such as state university boards of trustees, counties and municipalities, and corporations primarily acting as instrumentalities or agencies of the state, including the Florida Space Authority. Section 768.28(2), F.S.
[27] Section 768.28(9)(a), F.S.
[28] Section 768.28(5), F.S.
[29] *Id.*
[30] *Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997).
[31] *Id.* at 703, quoting from the *Restatement (Second) of Agency* s. 14N (1957).
[32] *Id.*
[33] *Id.* at 703.

Impaired Practitioner Program Consultant

Impaired practitioner consultants have sovereign immunity for the limited purpose of an emergency intervention, for actions taken within the scope of its contract with DOH.[34] Such contract must:

- Require the consultant to indemnify the state for any liabilities incurred up to the limits set out in chapter 768, F.S.;
- Require the consultant to establish a quality assurance program to monitor services delivered under the contract;
- Require the consultant's quality assurance program, treatment, and monitoring records to be evaluated quarterly;
- Require the consultant's quality assurance program to be subject to review and approval by DOH;
- Require the consultant to operate under policies and procedures approved by the DOH;
- Require the consultant to provide the DOH, for its approval, a policy and procedure manual that comports with all statutes, rules, and contract provisions;
- Require DOH to be entitled to review the records relating to the consultant's performance under the contract for purposes of management and financial audits or program evaluation;
- Require all performance measures and standards to be subject to verification and approval by DOH; and
- Allow DOH to terminate the contract with the consultant for noncompliance.[35]

The Department of Financial Services is required to defend the consultant, its officers, employees, and any person acting at the direction of the consultant for the limited purpose of an emergency intervention, when the consultant is unable to perform the intervention, from any legal action brought as a result of contracted program activities.

Mandatory Reporting

A licensed health care practitioner must report any person who the licensee knows is violating ch. 456, F.S., or the provisions of an individual practice act, or the rules adopted thereunder.[36] If a licensed health care practitioner knows that a person is unable to practice with reasonable skill and safety due to an impairment due to the use of alcohol or drugs, or due to a physical or mental illness in violation of ch. 456, F.S., or a practice act, that practitioner is obligated to report such impairment to the appropriate board, or DOH if there is not board.[37]

Failure to report such information may result in discipline for the licensed health care practitioner.

Effect of Proposed Changes

The bill authorizes, rather than requires, DOH to retain one or more consultants[38] to operate its impaired practitioner program.[39] DOH's contract with a consultant must specify the types of licenses, registrations, or certifications of the practitioners to be served by the consultant, and at a minimum, provide for the consultant to:

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[34] Section 768.28, F.S., provides the procedures that must be followed if an individual wishes to bring an action against the state for injury due to the negligence of a state employee, agent, or volunteer.
[35] Section 456.076(8), F.S.
[36] Section 456.072, F.S. *See also* s. 457.109, F.S., (acupuncture); s. 458.331, F.S., (medical practice); s. 459.015, F.S., (osteopathic medicine); s. 460.413, F.S., (chiropractic medicine); s. 461.013, F.S., (podiatric medicine); s. 462.14, F.S., (naturopathy); s. 463.016, F.S., (optometry); s. 464.018, F.S., (nursing); s. 465.016, F.S., (pharmacy); s. 466.028, F.S., (dentistry, dental hygiene, and dental laboratories); s. 467.203, F.S., (midwifery); s. 468.217, F.S.; (occupational therapy); and s. 474.221, F.S., (veterinary medicine).
[37] Section 456.072(1)(z), F.S.
[38] The bill defines consultant as the individual or entity which operates an approved impaired practitioner program pursuant to a contract with DOH.
[39] The bill defines impaired practitioner program as a program established by DOH by contract with one or more consultants to serve impaired or potentially impaired practitioners for the protection of the health, safety, and welfare of the public.

- Accept referrals of practitioners who have or are suspected of having an impairment;
- Arrange for the evaluation and treatment of such practitioners who have or are suspected of having an impairment as recommended by the consultant; and
- Monitor the recovery progress and status of impaired practitioners to ensure such practitioners are able to practice the profession in which they are licensed with skill and safety until such time as the consultant or DOH concludes such monitoring is no longer necessary or until such time the practitioner's participation in the program is terminated for material noncompliance[40] or inability to progress.[41]

The bill prohibits the consultant from evaluating, treating, or otherwise providing direct patient care to practitioners in the operation of the impaired practitioner program. Evaluations are provided by an evaluator,[42] and treatment is provided by a treatment program[43] or treatment provider.[44] Current law also prohibits the consultant from providing medical services.[45]

The bill requires the consultant to enter into a participant contract[46] with each impaired practitioner which establishes the terms of monitoring, which may be based on recommendations from evaluators, treatment programs, or treatment providers. If through the course of monitoring, the consultant determines that extended, additional, or amended terms are necessary to ensure public health, safety, and welfare, the consultant may modify the terms of the participant contract.

The bill requires DOH to refer a practitioner to the consultant if it receives a legally sufficient complaint alleging that the practitioner has an impairment and no other complaint exists against the practitioner. Such impairment will not be considered grounds for discipline if the practitioner:

- Acknowledges the impairment;
- Becomes a participant in an impaired practitioner program and successfully completes the participant contract;
- Voluntarily withdraws for practice or limits the scope of his or her practice, if required by the consultant;
- Provides to the consultant, or authorizes the consultant to obtain all records and information relating to the impairment from any and all sources and all other medical records requested by the consultant; and
- Authorizes the consultant, in the event of the practitioner's termination from the impaired practitioner program, to report the termination to DOH and provide DOH will all information in the consultant's possession relating to the practitioner.

Under current law, probable cause panels reviewing complaints against a practitioner may work directly with a consultant to determine if an impairment played a role in the complaint against a practitioner, and what, if any, disciplinary action needs to be taken. The bill requires the consultant to assist DOH and

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[40] The bill defines material noncompliance as an act or omission by a participant in violation of his or her participant contract as determined by the consultant or DOH.
[41] The bill defines inability to progress as a determination by the consultant based on a participant's response to treatment and prognosis that the participant is unable to safely practice despite compliance with treatment requirements and his or her participant contract.
[42] The bill defines an evaluator as a state-licensed or nationally certified individual who has been approved by a consultant or DOH, has completed an evaluator training program established by the consultant, and who is therefore authorized to evaluate practitioners as a part of impaired practitioner program.
[43] The bill defines treatment program as a DOH- or consultant-approved residential, intensive outpatient, partial hospitalization, or other program through which an impaired practitioner is treated based on the impaired practitioner's diagnosis and the treatment program approved by the consultant.
[44] The bill defines treatment provider as a DOH- or consultant-approved state-licensed or nationally certified individual who provides treatment to an impaired practitioner based on the practitioner's diagnosis and the treatment program approved by the consultant.
[45] Rule 64B31-10.001(1)(a), F.A.C.
[46] The bill defines participant contract as a formal written document outlining the requirements established by a consultant for a participant to successfully complete the impaired practitioner program, including the participant's monitoring plan.

licensure boards in matters involving impaired practitioners, including a determination of whether a practitioner is in fact impaired rather than this process taking place before probable cause panels.

The bill also authorizes emergency medical personnel who have or are suspected of having an impairment due to the use of alcohol or drugs, or as a result of a mental or physical condition to be reported to the consultant rather than DOH.

If an impaired practitioner self-reports to a consultant, the bill prohibits the consultant from providing information to DOH on such individual if the consultant has no knowledge of a pending complaint or disciplinary action and the individual is in compliance with the terms of the impaired practitioner program and participant contract, unless the participant authorizes the release of such information to DOH. The consultant does not have access to information regarding pending complaints or disciplinary, because complaints and investigative information are confidential and exempt until 10 days after probable cause is found or until waived.[47] Prior to that time, a consultant does not know if there is a pending complaint or disciplinary action unless DOH asks if a specific practitioner is a participant or the practitioner reports that he or she is the subject of a pending complaint or disciplinary action.

Currently, a licensed health care practitioner must report any person that he or she knows is in violation of the provisions of the core licensure statute (ch. 456, F.S.), or the provisions of an individual practice act. However, the bill creates an exception to this mandatory reporting to allow a licensee who knows that a person is unable to practice with reasonable skill and safety due to an impairment, to report such information to the consultant, rather than DOH or the applicable regulatory board. Both the core licensure statute and individual practice acts are amended to include this language.[48]

The bill authorizes an evaluator or treatment program to disclose information to the consultant regarding a referral or participant upon the request of the consultant and with the authorization of the practitioner when required by law.[49]

The bill requires a consultant to provide DOH with all the information in its possession for a referral or participant who is terminated from the impaired practitioner program for material noncompliance with the participant contract, inability to progress, or any other reason. If the consultant concludes that a practitioner has an impairment that affects his or her ability to practice and such impairment constitutes an immediate, serious danger to public health, the consultant must notify DOH, rather than the Surgeon General, and provide all information it has in its possession regarding that practitioner. This provision brings the process into the established disciplinary process at DOH.[50]

The bill retains the civil liability protections afforded to consultants for providing information regarding a participant to medical review committees[51] if the participant authorizes such disclosure, but eliminates such protection for DOH and the board. However, civil liability protections are provided elsewhere in current law. Section 766.101, F.S., currently provides that health care practitioners or other persons furnishing information to a medical review committee have no personal liability for any act or

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[47] Section 456.073(10), F.S.

[48] This includes the core licensure provision in s. 456.072, F.S., as well as s. 457.109, F.S., (acupuncture); s. 458.331, F.S., (medical practice); s. 459.015, F.S., (osteopathic medicine); s. 460.413, F.S., (chiropractic medicine); s. 461.013, F.S., (podiatric medicine); s. 462.14, F.S., (naturopathy); s. 463.016, F.S., (optometry); s. 464.018, F.S., (nursing); s. 465.016, F.S., (pharmacy); s. 466.028, F.S., (dentistry, dental hygiene, and dental laboratories); s. 467.203, F.S., (midwifery); s. 468.217, F.S.; (occupational therapy); and s. 474.221, F.S., (veterinary medicine).

[49] The bill defines a referral as a practitioner who has been referred or reported to a consultant for impaired practitioner program services, but is not under a participant contract. The bill defines a participant as a practitioner who is participating in the impaired practitioner program by having entered into a participant contract.

[50] *Supra* note 10.

[51] Pursuant to s. 766.101, F.S., a medical review committee are committees found within entities such as health care facilities, insurers, professional societies of health care practitioners, mental health treatment facilities, and rural health networks, which may evaluate the quality of health care rendered by health care practitioners, determine if services rendered were professionally indicated or performed in compliance with applicable standards of care, or determine if the cost of health care rendered was reasonable. A medical review committee may also be formed by an insurer to perform medical malpractice pre-suit procedures.

proceeding undertaken or performed within the scope of the functions of the committee, if the information provided is not intentionally fraudulent.[52]

The bill retains sovereign immunity for the consultant while acting within the scope of its duties under the contract with DOH. The bill also grants civil liability protection to the consultant, its directors, officers, employees, or agents for disclosure made pursuant to the impaired practitioner program, or for any other action or omission relating to the impaired practitioner program, or the consequences of such disclosure or action or omission, including without limitation, action by DOH against a license, registration, or certification. This means that in defending against claim or suit, the consultant may argue that it is not be liable for any damages; or alternatively, damages are limited under sovereign immunity. The bill retains the requirement in current law that the Department of Financial Services must also provide a defense for any claim, suit, action, or proceeding brought against the consultant.

If the consultant is retained to provide an impaired practitioner program for another state agency, the bill provides that the provisions of s. 456.076, F.S., will apply to that agencies impaired practitioner program. This provision will essentially bind another agency to the impaired practitioner program contract that DOH negotiates, without such agency being a party to the negotiations.

The bill repeals the authority of a regulatory board, or DOH if there no board, to adopt rules relating to the impaired practitioner program. Current rules designate the consultants of the impaired practitioner program as PRN and IPN and provide definitions; but do not provide any other provisions related to the operation of the program. The bill incorporates the definitions of the terms that are currently defined in rule. The designation of the consultant is no longer needed, as the bill authorizes DOH to contract with any entity that qualifies under the provisions of the bill.

The bill preserves the ability of a consultant to contract with a school to provide impaired practitioner services to its students but moves the provision to another paragraph within the subsection.

Under current law, the consultant has a public records exemption for all materials it receives pursuant to s. 456.076, F.S. Currently, the consultant receives information regarding the evaluation, as well as information from a treatment provider regarding the participant's participation in a treatment program. The bill retains the public records exemption and relocates it. The consultant will still hold the same information under the bill as it holds under current law.

The bill provides that the act shall take effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.076, F.S., relating to treatment programs for impaired practitioners.
Section 2: Amends s. 401.411, F.S., relating to disciplinary action; penalties.
Section 3: Amends s. 455.227, F.S., relating to grounds for discipline; penalties; enforcement.
Section 4: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 5: Amends s. 457.109, F.S., relating to disciplinary actions; grounds; action by the board.
Section 6: Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 7: Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 8: Amends s. 460.413, F.S., relating to grounds for disciplinary action; action by the board or department.
Section 9: Amends s. 461.013, F.S., relating to grounds for disciplinary action; action by the board; investigations by the department.
Section 10: Amends s. 462.14, F.S., relating to grounds for disciplinary action; action by the department.
Section 11: Amends s. 463.016, F.S., relating to grounds for disciplinary action; action by the board.

[52] Section 766.101, F.S.

Section 12: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 13: Amends s. 464.204, F.S., relating to denial, suspension, or revocation of certification; disciplinary actions.
Section 14: Amends s. 465.016, F.S., relating to disciplinary actions.
Section 15: Amends s. 466.028, F.S., relating to grounds for disciplinary action; action by the board.
Section 16: Amends s. 467.203, F.S., relating to disciplinary actions; penalties.
Section 17: Amends s. 468.217, F.S., relating to denial of or refusal to renew license; suspension and revocation of license and other disciplinary measures.
Section 18: Amends s. 468.3101, F.S., relating to disciplinary grounds and actions.
Section 19: Amends s. 474.221, F.S., relating to impaired practitioner provisions; applicability.
Section 20: Amends s. 483.825, F.S., relating to grounds for disciplinary action.
Section 21: Provides that the act shall take effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Due to the expansion of individuals that are afforded a defense by the Department of Financial Services for claims, actions, suits, or proceedings, there may be an indeterminate, insignificant negative fiscal impact on the Risk Management Trust Fund.[53]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[53] Department of Financial Services, "House Bill 229 Analysis," (January 25, 2017), on file with the Health Quality Subcommittee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill repeals the authority of DOH to adopt rules designating an approved impaired practitioner program for professions that do not have a board, and provides DOH the freedom to contract with any entity to operate an impaired practitioner program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2107, the Health Quality Subcommittee adopted an amendment that did the following:

- Amended the definition of impairment by deleting the term "potential" to avoid conflict with the Americans with Disability Act.
- Added mandatory health care practitioner reports of an impaired practitioner to the definition of "referral".
- Made technical improvements to the subsection which delineates the contract requirements for a consultant, but makes no substantive changes.
- Changed the terms "certify" and "decline to certify" to "approval" and "intent to deny" to reflect actual practice.
- Clarified that, in the case of a self-referral, a consultant would only report the impaired practitioner to DOH if the practitioner has knowledge of a pending complaint or investigation since complaint and investigatory information is confidential and exempt from public records until 10 days after a finding is made by a probable cause panel or waived.
- Reinstated and amended language that specifies that the consultant is an agent of the state for purposes of sovereign immunity when acting pursuant to its contract.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

A bill to be entitled

An act relating to programs for impaired health care practitioners; amending s. 456.076, F.S.; revising provisions related to impaired practitioner programs; providing definitions; deleting a requirement that the Department of Health designate approved programs by rule; deleting provisions related to probable cause panels; deleting provisions related to agency of specified persons; amending ss. 401.411, 456.072, 457.109, 458.331, 459.015, 460.413, 461.013, 462.14, 463.016, 464.018, 465.016, 466.028, 467.203, 468.217, and 483.825, F.S; providing that an impaired practitioner may be reported to a consultant rather than the department under certain circumstances; amending s. 468.3101, F.S.; revising grounds for disciplinary action to include termination from an impaired practitioner program under certain circumstances; amending ss. 455.227, 464.204, and 474.221, F.S.; conforming provisions; providing an effective date.

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

Section 1. Section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs ~~Treatment programs for impaired practitioners~~.—

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

(a) "Consultant" means the individual or entity which operates an approved impaired practitioner program pursuant to a contract with the department and who is retained by the department as provided in subsection (2).

(b) "Evaluator" means a state-licensed or nationally certified individual who has been approved by a consultant or the department, has completed an evaluator training program established by the consultant, and who is therefore authorized to evaluate practitioners as part of an impaired practitioner program.

(c) "Impaired practitioner" means a practitioner with an impairment.

(d) "Impaired practitioner program" means a program established by the department by contract with one or more consultants to serve impaired and potentially impaired practitioners for the protection of the health, safety, and welfare of the public.

(e) "Impairment" means an impairing health condition that is the result of the misuse or abuse of alcohol, drugs, or both, or a mental or physical condition which could affect a practitioner's ability to practice with skill and safety.

(f) "Inability to progress" means a determination by a

consultant based on a participant's response to treatment and prognosis that the participant is unable to safely practice despite compliance with treatment requirements and his or her participant contract.

(g) "Material noncompliance" means an act or omission by a participant in violation of his or her participant contract as determined by the department or consultant.

(h) "Participant" means a practitioner who is participating in the impaired practitioner program by having entered into a participant contract. A practitioner ceases to be a participant when the participant contract is successfully completed or is terminated for any reason.

(i) "Participant contract" means a formal written document outlining the requirements established by a consultant for a participant to successfully complete the impaired practitioner program, including the participant's monitoring plan.

(j) "Practitioner" means a person licensed, registered, certified, or regulated by the department under part III of chapter 401; chapters 457 through 467; parts I, II, III, V, X, XIII, or XIV of chapter 468; chapter 478; chapter 480; part III or IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491, Florida Statutes; or an applicant under the same laws.

(k) "Referral" means a practitioner who has been referred, either as a self-referral or otherwise, or reported to a

consultant for impaired practitioner program services, but who is not under a participant contract.

(l) "Treatment program" means a department or consultant-approved residential, intensive outpatient, partial hospitalization, or other program through which an impaired practitioner is treated based on the impaired practitioner's diagnosis and the treatment plan approved by the consultant.

(m) "Treatment provider" means a department or consultant-approved state-licensed or nationally-certified individual who provides treatment to an impaired practitioner based on the practitioner's individual diagnosis and a treatment plan approved by the consultant ~~For professions that do not have impaired practitioner programs provided for in their practice acts, the department shall, by rule, designate approved impaired practitioner programs under this section. The department may adopt rules setting forth appropriate criteria for approval of treatment providers. The rules may specify the manner in which the consultant, retained as set forth in subsection (2), works with the department in intervention, requirements for evaluating and treating a professional, requirements for continued care of impaired professionals by approved treatment providers, continued monitoring by the consultant of the care provided by approved treatment providers regarding the professionals under their care, and requirements related to the consultant's expulsion of professionals from the program~~.

(2)(a) The department may ~~shall~~ retain one or more ~~impaired practitioner~~ consultants to operate its impaired practitioner program. Each consultant ~~who are each licensees under the jurisdiction of the Division of Medical Quality Assurance within the department and who~~ must be:

1. A practitioner ~~or recovered practitioner~~ licensed under chapter 458, chapter 459, or part I of chapter 464; or

2. An entity that employs:

a. A medical director who is ~~must be a practitioner or recovered practitioner~~ licensed under chapter 458 or chapter 459; or

b. An executive director who is ~~must be a registered nurse or a recovered registered nurse~~ licensed under part I of chapter 464.

(3) The terms and conditions of the impaired practitioner program must be established by the department by contract with a consultant for the protection of the health, safety, and welfare of the public and must provide, at a minimum, that the consultant:

(a) Accept referrals of practitioners who have or are suspected of having an impairment;

(b) Arrange for the evaluation and treatment of such practitioners as recommended by the consultant;

(c) Monitor the recovery progress and status of impaired practitioners to ensure that such practitioners are able to

practice their profession with skill and safety. Such monitoring must continue until the consultant or department concludes that monitoring by the consultant is no longer required for the protection of the public or the practitioner's participation in the program is terminated for material noncompliance or inability to progress; and

(d) May not evaluate, treat, or otherwise provide direct patient care to a practitioner in the operation of the impaired practitioner program.

(4) The department shall specify, in its contract with each consultant, the types of licenses, registrations, or certifications of the practitioners to be served by that consultant.

(5) A consultant shall enter into a participant contract with an impaired practitioner and shall establish the terms of monitoring and shall include the terms in a participant contract. In establishing the terms of monitoring, the consultant may consider the recommendations of one or more approved evaluators, treatment programs, or treatment providers. A consultant may modify the terms of monitoring if the consultant concludes, through the course of monitoring, that extended, additional, or amended terms of monitoring are required for the protection of the health, safety, and welfare of the public.

(6)~~(b)~~ A ~~An entity retained as an impaired practitioner~~

consultant ~~under this section which employs a medical director or an executive director~~ is not required to be licensed as a substance abuse provider or mental health treatment provider under chapter 394, chapter 395, or chapter 397 for purposes of providing services under this program.

(7)~~(c)1.~~ Each ~~The~~ consultant shall assist the department and licensure boards on matters of impaired practitioners, including the determination of ~~probable cause panel and the department in carrying out the responsibilities of this section. This includes working with department investigators to determine~~ whether a practitioner is, in fact, impaired, as specified in the consultant's contract with the department.

~~2. The consultant may contract with a school or program to provide services to a student enrolled for the purpose of preparing for licensure as a health care practitioner as defined in this chapter or as a veterinarian under chapter 474 if the student is allegedly impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition. The department is not responsible for paying for the care provided by approved treatment providers or a consultant.~~

~~(d) A medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or another school providing for the education of students enrolled in preparation for licensure as a health care practitioner as defined in this chapter or a veterinarian under~~

~~chapter 474 which is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant retained by the department or for disciplinary actions that adversely affect the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provided by such consultant, if the school, in referring the student or taking disciplinary action, adheres to the due process procedures adopted by the applicable accreditation entities and if the school committed no intentional fraud in carrying out the provisions of this section.~~

(8)~~(3)~~ Before issuing an approval of or intent to deny an application for licensure, each board and profession within the Division of Medical Quality Assurance may delegate to its chair or other designee its authority to determine~~, before certifying or declining to certify an application for licensure to the department,~~ that an applicant for licensure under its jurisdiction may have an impairment ~~be impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition that could affect the applicant's ability to practice with skill and safety~~. Upon such determination, the chair or other designee may refer the applicant to the consultant to facilitate ~~for~~ an evaluation

before the board issues an approval of ~~certifies~~ or intent to deny ~~declines to certify~~ his or her application ~~to the department~~. If the applicant agrees to be evaluated ~~by the consultant~~, the department's deadline for approving or denying the application pursuant to s. 120.60(1) is tolled until the evaluation is completed and the result of the evaluation and recommendation ~~by the consultant~~ is communicated to the board by the consultant. If the applicant declines to be evaluated ~~by the consultant~~, the board shall issue an approval of or intent to deny ~~certify or decline to certify~~ the applicant's application ~~to the department~~ notwithstanding the lack of an evaluation and recommendation by the consultant.

(9) ~~(4)~~(a) When ~~Whenever~~ the department receives a ~~written or oral~~ legally sufficient complaint alleging that a practitioner has an impairment ~~licensee under the jurisdiction of the Division of Medical Quality Assurance within the department is impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition which could affect the licensee's ability to practice with skill and safety,~~ and no complaint exists against the practitioner ~~licensee~~ other than impairment ~~exists~~, the department shall refer the practitioner to the consultant, along with all information in the department's possession relating to the impairment. The impairment does ~~reporting of such information shall~~ not constitute grounds for discipline pursuant

to s. 456.072 or ~~the corresponding grounds for discipline within~~ the applicable practice act if ~~the probable cause panel of the appropriate board, or the department when there is no board, finds~~:

1. The practitioner ~~licensee~~ has acknowledged the impairment ~~problem~~.

2. The practitioner becomes a participant ~~licensee has voluntarily enrolled~~ in an impaired practitioner program and successfully completes a participant contract under terms established by the consultant ~~appropriate, approved treatment program~~.

3. The practitioner ~~licensee~~ has voluntarily withdrawn from practice or has limited the scope of his or her practice if ~~as~~ required by the consultant~~, in each case, until such time as the panel, or the department when there is no board, is satisfied the licensee has successfully completed an approved treatment program~~.

4. The practitioner ~~licensee~~ has provided to the consultant, or has authorized the consultant to obtain, all records and information relating to the impairment from any source and all other medical records of the practitioner requested by the consultant ~~executed releases for medical records, authorizing the release of all records of evaluations, diagnoses, and treatment of the licensee, including records of treatment for emotional or mental conditions, to the consultant~~.

~~The consultant shall make no copies or reports of records that do not regard the issue of the licensee's impairment and his or her participation in a treatment program.~~

5. The practitioner has authorized the consultant, in the event of the practitioner's termination from the impaired practitioner program, to report the termination to the department and provide the department with copies of all information in the consultant's possession relating to the practitioner.

(b) To encourage practitioners who are or may be impaired to voluntarily self-refer to a consultant, the consultant may not provide information to the department relating to a self-referring participant if the consultant has no knowledge of a pending department investigation, complaint, or disciplinary action against the participant and if the participant is in compliance with the terms of the impaired practitioner program and any participant contract, unless authorized by the participant ~~If, however, the department has not received a legally sufficient complaint and the licensee agrees to withdraw from practice until such time as the consultant determines the licensee has satisfactorily completed an approved treatment program or evaluation, the probable cause panel, or the department when there is no board, shall not become involved in the licensee's case~~.

~~(c) Inquiries related to impairment treatment programs~~

~~designed to provide information to the licensee and others and which do not indicate that the licensee presents a danger to the public shall not constitute a complaint within the meaning of s. 456.073 and shall be exempt from the provisions of this subsection.~~

~~(d) Whenever the department receives a legally sufficient complaint alleging that a licensee is impaired as described in paragraph (a) and no complaint against the licensee other than impairment exists, the department shall forward all information in its possession regarding the impaired licensee to the consultant. For the purposes of this section, a suspension from hospital staff privileges due to the impairment does not constitute a complaint.~~

~~(e) The probable cause panel, or the department when there is no board, shall work directly with the consultant, and all information concerning a practitioner obtained from the consultant by the panel, or the department when there is no board, shall remain confidential and exempt from the provisions of s. 119.07(1), subject to the provisions of subsections (6) and (7).~~

~~(f) A finding of probable cause shall not be made as long as the panel, or the department when there is no board, is satisfied, based upon information it receives from the consultant and the department, that the licensee is progressing satisfactorily in an approved impaired practitioner program and~~

~~no other complaint against the licensee exists.~~

(10)~~(5)~~ In any disciplinary action for a violation other than impairment in which a practitioner ~~licensee~~ establishes the violation for which the licensee is being prosecuted was due to or connected with impairment and further establishes the practitioner ~~licensee~~ is satisfactorily progressing through or has successfully completed an impaired practitioner program ~~approved treatment program~~ pursuant to this section, such information may be considered by the board, or the department when there is no board, as a mitigating factor in determining the appropriate penalty. This subsection does not limit mitigating factors the board may consider.

(11)~~(6)~~(a) Upon request by the consultant, and with the authorization of the practitioner when required by law, an approved evaluator, treatment program, or treatment provider shall~~, upon request,~~ disclose to the consultant all information in its possession regarding a referral or participant ~~the issue of a licensee's impairment and participation in the treatment program. All information obtained by the consultant and department pursuant to this section is confidential and exempt from the provisions of s. 119.07(1), subject to the provisions of this subsection and subsection (7)~~. Failure to provide such information to the consultant is grounds for withdrawal of approval of such evaluator, treatment program, or treatment provider.

(b) When a referral or participant is terminated from the impaired practitioner program for material noncompliance with a participant contract, inability to progress, or any other reason, the consultant shall disclose all information in the consultant's possession relating to the practitioner to the department ~~If in the opinion of the consultant, after consultation with the treatment provider, an impaired licensee has not progressed satisfactorily in a treatment program, all information regarding the issue of a licensee's impairment and participation in a treatment program in the consultant's possession shall be disclosed to the department~~. Such disclosure shall constitute a complaint pursuant to the general provisions of s. 456.073. In addition, whenever the consultant concludes that impairment affects a practitioner's ~~licensee's~~ practice and constitutes an immediate, serious danger to the public health, safety, or welfare, the consultant shall immediately communicate such ~~that~~ conclusion ~~shall be communicated~~ to the department and disclose all information in the consultant's possession relating to the practitioner to the department ~~State Surgeon General~~.

(12) All information obtained by the consultant pursuant to this section is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(13) ~~(7)~~ A consultant, or a director, officer, employee or agent of a consultant, may not be held liable financially or have a cause of action for damages brought against them for

making a disclosure pursuant to this section, or for any other action or omission relating to the impaired practitioner program, or the consequences of such disclosure or action or omission, including, without limitation, action by the department against a license, registration, or certification. ~~licensee, or approved treatment provider who makes a disclosure pursuant to this section is not subject to civil liability for such disclosure or its consequences.~~

(14) The provisions of s. 766.101 apply to any consultant, employee, or agent of a consultant in regards to providing information relating to a participant to a medical review committee if the participant authorized such disclosure ~~officer, employee, or agent of the department or the board and to any officer, employee, or agent of any entity with which the department has contracted pursuant to this section~~.

(15)(a) ~~(8)(a)~~ A consultant retained pursuant to this section and ~~subsection (2),~~ a consultant's directors, officers, ~~and~~ employees, or agents ~~and those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention~~ shall be considered agents of the department for purposes of s. 768.28 while acting within the scope of the consultant's duties under the contract with the department ~~if the contract complies with the requirements of this section~~. ~~The~~

~~contract must require that:~~

~~1. The consultant indemnify the state for any liabilities incurred up to the limits set out in chapter 768.~~

~~2. The consultant establish a quality assurance program to monitor services delivered under the contract.~~

~~3. The consultant's quality assurance program, treatment, and monitoring records be evaluated quarterly.~~

~~4. The consultant's quality assurance program be subject to review and approval by the department.~~

~~5. The consultant operate under policies and procedures approved by the department.~~

~~6. The consultant provide to the department for approval a policy and procedure manual that comports with all statutes, rules, and contract provisions approved by the department.~~

~~7. The department be entitled to review the records relating to the consultant's performance under the contract for the purpose of management audits, financial audits, or program evaluation.~~

~~8. All performance measures and standards be subject to verification and approval by the department.~~

~~9. The department be entitled to terminate the contract with the consultant for noncompliance with the contract.~~

(b) In accordance with s. 284.385, the Department of Financial Services shall defend any claim, suit, action, or proceeding, including a claim, suit, action, or proceeding for

injunctive, affirmative, or declaratory relief, against the consultant, the consultant's directors, officers, ~~or~~ employees, or agents brought as the result of any action or omission relating to the impaired practitioner program ~~or those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention, which claim, suit, action, or proceeding is brought as a result of an act or omission by any of the consultant's officers and employees and those acting under the direction of the consultant for the limited purpose of an emergency intervention on behalf of the licensee or student when the consultant is unable to perform such intervention, if the act or omission arises out of and is in the scope of the consultant's duties under its contract with the department~~.

(16)~~(c)~~ If a ~~the~~ consultant retained by the department pursuant to this section ~~subsection (2)~~ is also retained by another ~~any other~~ state agency to operate an impaired practitioner program for that agency, this section also applies to the consultant's operation of an impaired practitioner program for that agency~~, and if the contract between such state agency and the consultant complies with the requirements of this section, the consultant, the consultant's officers and employees, and those acting under the direction of the consultant for the limited purpose of an emergency intervention~~

~~on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention shall be considered agents of the state for the purposes of this section while acting within the scope of and pursuant to guidelines established in the contract between such state agency and the consultant~~.

(17)~~(9)~~ A ~~An impaired practitioner consultant is the official custodian of records relating to the referral of an impaired licensee or applicant to that consultant and any other interaction between the licensee or applicant and the consultant. The~~ consultant may disclose to a referral or participant documents, records, or other information from the consultant's file on the referral or participant ~~the impaired licensee or applicant or his or her designee any information that is disclosed to or obtained by the consultant or that is confidential under paragraph (6)(a), but only~~ to the extent that it is necessary to do so to carry out the consultant's duties under the impaired practitioner program and this section, or as otherwise required by law. ~~The department, and any other entity that enters into a contract with the consultant to receive the services of the consultant, has direct administrative control over the consultant to the extent necessary to receive disclosures from the consultant as allowed by federal law.~~ If a disciplinary proceeding is pending, a referral or participant may obtain a complete copy of the consultant's file from the

department as provided by ~~an impaired licensee may obtain such information from the department under~~ s. 456.073.

(18)(a) The consultant may contract with a school or program to provide impaired practitioner program services to a student enrolled for the purpose of preparing for licensure as a health care practitioner as defined in this chapter or as a veterinarian under chapter 474 if the student has or is suspected of having an impairment. The department is not responsible for paying for the care provided by approved treatment providers or approved treatment programs or for the services provided by a consultant to a student.

(b) A medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or another school providing for the education of students enrolled in preparation for licensure as a health care practitioner, as defined in this chapter, or a veterinarian under chapter 474, which is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant retained by the department or for disciplinary actions that adversely affect the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provided by such consultant, if the school, in referring the student or taking disciplinary action, adheres to

the due process procedures adopted by the applicable accreditation entities and if the school committed no intentional fraud in carrying out the provisions of this section.

Section 2. Paragraph (l) of subsection (1) of section 401.411, Florida Statutes, is amended to read:

401.411 Disciplinary action; penalties.—

(1) The department may deny, suspend, or revoke a license, certificate, or permit or may reprimand or fine any licensee, certificateholder, or other person operating under this part for any of the following grounds:

(l) The failure to report to the department any person known to be in violation of this part. However, a professional known to be operating under this part without reasonable skill and without regard for the safety of the public by reason of illness, drunkenness, or the use of drugs, narcotics, chemicals, or any other substance, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 3. Paragraph (u) of subsection (1) of section 455.227, Florida Statutes, is amended to read:

455.227 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be

taken:

(u) Termination from an impaired practitioner program ~~a treatment program for impaired practitioners~~ as described in s. 456.076 for failure to comply, without good cause, with the terms of the monitoring or participant ~~treatment~~ contract entered into by the licensee or failing to successfully complete a drug or alcohol treatment program.

Section 4. Paragraphs (i) and (hh) of subsection (1) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board. However, a person who the licensee knows is unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

(hh) Being terminated from an impaired practitioner program ~~a treatment program for impaired practitioners~~, which is

overseen by a ~~an impaired practitioner~~ consultant as described in s. 456.076, for failure to comply, without good cause, with the terms of the monitoring or participant ~~treatment~~ contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

Section 5. Paragraph (f) of subsection (1) of section 457.109, Florida Statutes, is amended to read:

457.109 Disciplinary actions; grounds; action by the board.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(f) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department. However, a person who the licensee knows is unable to practice acupuncture with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 6. Paragraph (e) of subsection (1) of section 458.331, Florida Statutes, is amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a

license or disciplinary action, as specified in s. 456.072(2):

(e) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows is unable to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department ~~A treatment provider approved pursuant to s. 456.076 shall provide the department or consultant with information in accordance with the requirements of s. 456.076(4), (5), (6), (7), and (9)~~.

Section 7. Paragraph (e) of subsection (1) of section 459.015, Florida Statutes, is amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(e) Failing to report to the department or the department's impaired professional consultant any person who the licensee or certificateholder knows is in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows is unable to practice

osteopathic medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department ~~A treatment provider, approved pursuant to s. 456.076, shall provide the department or consultant with information in accordance with the requirements of s. 456.076(4), (5), (6), (7), and (9)~~.

Section 8. Paragraph (g) of subsection (1) of section 460.413, Florida Statutes, is amended to read:

460.413 Grounds for disciplinary action; action by board or department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(g) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows is unable to practice chiropractic medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to

the department.

Section 9. Paragraph (f) of subsection (1) of section 461.013, Florida Statutes, is amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(f) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows is unable to practice podiatric medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 10. Paragraph (f) of subsection (1) of section 462.14, Florida Statutes, is amended to read:

462.14 Grounds for disciplinary action; action by the department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(f) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules

of the department. However, a person who the licensee knows is unable to practice naturopathic medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 11. Paragraph (l) of subsection (1) of section 463.016, Florida Statutes, is amended to read:

463.016 Grounds for disciplinary action; action by the board.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(l) Willfully failing to report any person who the licensee knows is in violation of this chapter or of rules of the department or the board. However, a person who the licensee knows is unable to practice optometry with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 12. Paragraph (k) of subsection (1) of section 464.018, Florida Statutes, is amended to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(k) Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department or the board. However, a person who the licensee knows is unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department~~; however, if the licensee verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the licensee is required to report such person only to an impaired professionals consultant~~.

Section 13. Paragraph (c) of subsection (2) of section 464.204, Florida Statutes, is amended to read:

464.204 Denial, suspension, or revocation of certification; disciplinary actions.—

(2) When the board finds any person guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following penalties:

(c) Imposition of probation or restriction of certification, including conditions such as corrective actions as retraining or compliance with the department's impaired

practitioner program, operated by a consultant as described in s. 456.076 ~~an approved treatment program for impaired practitioners~~.

Section 14. Paragraph (o) of subsection (1) of section 465.016, Florida Statutes, is amended to read:

465.016 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(o) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the pharmacist knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the pharmacist also provides services. However, a person who the licensee knows is unable to practice medicine or osteopathic medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 15. Paragraph (f) of subsection (1) of section 466.028, Florida Statutes, is amended to read:

466.028 Grounds for disciplinary action; action by the

board.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(f) Failing to report to the department any person who the licensee knows, or has reason to believe, is clearly in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows, or has reason to believe, is clearly unable to practice her or his profession with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 16. Paragraph (h) of subsection (1) of section 467.203, Florida Statutes, is amended to read:

467.203 Disciplinary actions; penalties.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(h) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department. However, a person who the licensee knows is unable to practice midwifery with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a

result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 17. Paragraph (f) of subsection (1) of section 468.217, Florida Statutes, is amended to read:

468.217 Denial of or refusal to renew license; suspension and revocation of license and other disciplinary measures.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(f) Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department or of the board. However, a person who the licensee knows is unable to practice occupational therapy with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 18. Paragraph (n) of subsection (1) of section 468.3101, Florida Statutes, is amended to read:

468.3101 Disciplinary grounds and actions.—

(1) The department may make or require to be made any investigations, inspections, evaluations, and tests, and require the submission of any documents and statements, which it

considers necessary to determine whether a violation of this part has occurred. The following acts shall be grounds for disciplinary action as set forth in this section:

(n) Being terminated from an impaired practitioner program operated by a consultant as described in s. 456.076 for failure to comply, without good cause, with the terms of monitoring or a participant contract entered into by the licensee, or for not successfully completing a drug treatment or alcohol treatment program ~~Failing to comply with the recommendations of the department's impaired practitioner program for treatment, evaluation, or monitoring. A letter from the director of the impaired practitioner program that the certificateholder is not in compliance shall be considered conclusive proof under this part~~.

Section 19. Section 474.221, Florida Statutes, is amended to read:

474.221 Impaired practitioner provisions; applicability.—Notwithstanding the transfer of the Division of Medical Quality Assurance to the Department of Health or any other provision of law to the contrary, veterinarians licensed under this chapter shall be governed by the ~~treatment of~~ impaired practitioner program provisions of s. 456.076 as if they were under the jurisdiction of the Division of Medical Quality Assurance, except that for veterinarians the Department of Business and Professional Regulation shall, at its option, exercise any of

the powers granted to the Department of Health by that section, and "board" shall mean board as defined in this chapter.

Section 20. Paragraph (o) of subsection (1) of section 483.825, Florida Statutes, is amended to read:

483.825 Grounds for disciplinary action.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(o) Failing to report to the department a person or other licensee who the licensee knows is in violation of this chapter or the rules of the department or board adopted hereunder. However, a person or other licensee who the licensee knows is unable to perform or report on clinical laboratory examinations with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 21. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 619 Consolidation of Medicaid Waiver Programs
SPONSOR(S): Health Innovation Subcommittee, Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 694

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N, As CS	Tuszynski	Poche
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Health (DOH) and Department of Elder Affairs (DOEA).

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care Managed Medical Assistance (MMA) program. In addition, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the Medicaid Managed Care Long-term Care (LTC) program. The LTC program provides services for elderly and disabled individuals who require long-term nursing facility level of care.

Florida also operates multiple Home and Community Based Services (HCBS) waivers to provide services, not otherwise available through Medicaid, intended to prevent or delay institutional placement. The HCBS waivers vary: some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities).

CS/HB 619 requires the consolidation of individuals enrolled in three HCBS waivers into the LTC program by January 1, 2018: the Project AIDS Care (PAC) waiver, Adult Cystic Fibrosis (ACF) waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver. The bill requires AHCA to seek federal approval to terminate those waivers once all eligible Medicaid beneficiaries have transitioned into the LTC program.

The bill expands eligibility requirements for the MMA and LTC programs to accommodate the PAC and ACF waiver populations and deletes language relating to waiver consolidation that would be obsolete upon passage. The bill also deletes the requirement for AHCA to operate a prescription drug management program that has become duplicative of services available in the Medicaid managed care model.

The bill does not have a fiscal impact on state agencies; however, funding will be required to be transferred from DOH to AHCA to implement the provisions contained within the bill.

The bill provides for an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.6%, of the children in Florida.[4] Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017. Florida's program is the 4th largest in the nation by enrollment, and the 6th largest in terms of expenditures.[5]

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[6] In addition to the

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed February 28, 2017).
[5] The Henry J. Kaiser Family Foundation, State Health Facts, Total Medicaid Spending FY 2015 and Total Monthly Medicaid and CHIP Enrollment Nov. 2016, available at http://kff.org/statedata/ (last viewed March 3, 2017).
[6] S. 409.964, F.S.

Section 1115 waiver for the MMA program, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-term Care (LTC) program.[7]

Approximately 82% of the Medicaid population in Florida is enrolled in the MMA and LTC programs.[8]

Florida's Medicaid Managed Care Long-term Care Program

The LTC program provides long-term care services to eligible Medicaid beneficiaries. Individuals must enroll in the LTC program if they are age 65 or older and eligible for Medicaid, age 18 or older and eligible for Medicaid by reason of a disability, or determined by the Comprehensive Assessment and Review of Long-term Care Services (CARES) unit[9] at DOEA to need nursing facility level of care[10] and also meets one or more established criteria, such as receiving TANF or enrolled in hospice care.[11]

The LTC program also allows individuals who are eligible for various other Home and Community-based Services (HCBS) waivers[12] to enroll. Such waivers include:

- Developmental Disabilities Waiver (iBudget);
- Traumatic Brain and Spinal Cord Injury Waiver;
- Project AIDS Care Waiver; and
- Adult Cystic Fibrosis Waiver.[13]

The following chart details the minimum covered services available to individuals enrolled in the LTC program:

LTC Program Minimum Covered Services[14]		
Adult Companion Care	Home accessibility adaptation	Nursing facility
Adult day health care	Home-delivered meals	Nutritional assessment / risk reduction
Assisted living	Homemaker	Personal care

[7] Id.
[8] Supra, FN 4.
[9] CARES is a federally mandated pre-admission screening program to assess each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through other Medicaid waivers.
[10] S. 409.985(3), F.S.; "Nursing facility care" means the individual:
(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;
(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or
(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.
[11] Agency for Health Care Administration, Statewide Medicaid Managed Care, *Long-term Care Program Snapshot*, December 6, 2016, available at https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last accessed February 27, 2017).
[12] Infra, FN 16; Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement. Florida's HCBS waivers vary on a number of dimensions. Some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities). Waivers also differ with respect to the number and types of services provided, payment method, and whether waiver services are available statewide or limited to a few counties.
[13] Supra, FN 11.
[14] Id.

LTC Program Minimum Covered Services[14]		
Assistive care services	Hospice	Personal emergency response system
Attendant nursing care	Intermittent and Skilled Nursing	Respite care
Behavioral management	Medical equipment and supplies	Occupational, physical, respiratory and speech therapy
Care coordination / Case management	Medication administration	Non-emergency Transportation
Caregiver training	Medication Management	

LTC plan providers also cover some expanded benefits, such as dental, emergency financial assistance, non-medical transportation, over-the-counter medications/supplies, and vision services.[15]

Traumatic Brain and Spinal Cord Injury Waiver

The Traumatic Brain and Spinal Cord Injury (TB/SCI) waiver is an HCBS waiver operated by DOH that provides services for individuals with traumatic brain injuries and spinal cord injuries.[16] For purposes of the waiver, "traumatic brain injury" is an injury that produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits and "spinal cord injury" is an injury that has significant involvement of two of the following: motor deficit, sensory deficit, or bowel and bladder dysfunction.[17] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have one of the conditions previously described, and meet nursing home level of care as determined by CARES.[18]

The TB/SCI waiver includes services such as assistive technologies, attendant care, adult companion, counseling, personal care, and support coordination. Currently, the TB/SCI waiver has approximately 350 individuals enrolled with 350 on the waitlist.[19]

Adult Cystic Fibrosis Waiver

The Adult Cystic Fibrosis (ACF) waiver is an HCBS waiver operated by DOH that provides services for individuals with a diagnosis of cystic fibrosis; a chronic, progressive, and terminal genetic disorder that affects a person's lungs and digestive system.[20] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have a diagnosis of cystic fibrosis, and meet nursing home level of care as determined by CARES.[21]

The ACF waiver includes services such as case management, counseling, personal care, prescription drugs, respite care, and respiratory therapy. Currently, the ACF waiver has approximately 140 individuals enrolled with none on the waitlist.[22]

Project AIDS Care Waiver

The Project AIDS Care (PAC) waiver is an HCBS waiver operated by AHCA that provides services for individuals with a diagnosis of acquired immune deficiency syndrome (AIDS). To be eligible, individuals

[15] Id.
[16] Office of Program Policy Analysis and Government Accountability, *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 13-07, March 2013, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1307rpt.pdf (last accessed February 27, 2017).
[17] Id.
[18] Id.
[19] Agency for Health Care Administration, Agency Analysis of 2017 House Bill 619, p. 3 (Feb. 6, 2017).
[20] Supra, FN 16.
[21] Id.
[22] Supra, FN 19

must be Medicaid eligible, have a diagnosis of AIDS, have an AIDS-related opportunistic infection, be at risk for hospitalization, meet income eligibility requirements of the Social Security Administration for SSI,[23] and not be enrolled in the MMA or LTC programs.[24] To meet SSI income requirements, an individual must not earn more than $2,205 per month, or 300% of the Federal Benefits Rate (FBR).[25]

The PAC waiver includes services such as case management, home-delivered meals, personal care, restorative massage, specialized medical equipment, and skilled nursing. Currently, the PAC waiver has approximately 7,800 individuals enrolled with none on the waitlist.

Medication Therapy Management Program

Section 409.912(8)(a)11., F.S., requires AHCA to implement a Medicaid prescription drug management system that determines appropriate practice patterns and clinical guidelines to improve prescribing, dispensing, and use of prescription drugs for certain Medicaid beneficiaries. The system must improve quality of care and prescribing practices using best practice guidelines to improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs.[26]

AHCA contracts with the University of Florida College Of Pharmacy to administer the Medication Therapy Management (MTM) program. The MTM program uses a delivery model that allows pharmacists to work collaboratively with the patient and his or her health care provider to develop treatment plans and optimize drug treatment and therapeutic outcomes.[27] The MTM program uses telephonic follow-up assessments, customized interventions, member engagement, and intermediary services to connect patients, pharmacists, and providers.[28]

To be eligible for MTM services, a recipient must not be enrolled in a health plan and receive their prescribed drug and other medical care through the Medicaid fee-for-service delivery system. The MTM program has an annual capacity of 250 individuals. Currently, the program has 50 individuals enrolled.

Effect of Proposed Bill

CS/HB 619 requires PAC, ACF, and TB/SCI waiver beneficiaries to transition to the LTC program by January 1, 2018. Once all eligible Medicaid beneficiaries have transitioned, AHCA must seek federal approval to terminate the waivers. Waiver consolidation removes administrative burdens on AHCA and DOH by transferring Medicaid beneficiaries from these HCBS waivers into the LTC program. Similar services, and in some cases expanded services, are available to the waiver beneficiaries in the LTC program as were available through the waivers.

Project AIDS Care Waiver Consolidation

The bill transfers approximately 7,800 individuals from the PAC waiver to the LTC program.

The bill amends eligibility requirements, subject to federal approval, for individuals who would otherwise be eligible for the PAC waiver but do not meet the eligibility requirements for the LTC program. The bill

[23] SSI is the Supplemental Security Income program, a federal income supplement program designed to help aged, blind, and disabled people with little to no income by providing cash to meet basic needs such as food, clothing and shelter; *See* Social Security Administration, Supplemental Security Income Home Page – 2016 Edition, *What is Supplemental Security Income?*, available at https://www.ssa.gov/ssi/ (last accessed February 27, 2017).
[24] Supra, FN 16.
[25] Current FBR is $735 per month; Department of Children and Families, *SSI-Related Programs – Financial Eligibility Standards*, available at http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last accessed February 26, 2017).
[26] S. 409.912(8)(a)11.b., F.S.
[27] University of Florida College of Pharmacy, Services, *Medication Therapy Management*, available at http://mmc.pharmacy.ufl.edu/services/mtm/ (last accessed February 28, 2017).
[28] University of Florida College of Pharmacy, Services, *Performance Improvement Interventions*, available at http://mmc.pharmacy.ufl.edu/services/mtm/ (last accessed March 2, 2017).

makes those individuals with a diagnosis of AIDS, an AIDS-related opportunistic infection, at risk of hospitalization as determined by AHCA, and income at or below 300% of the FBR eligible for Medicaid. This change in the eligibility requirement would allow an individual otherwise eligible for the PAC waiver, who does not meet the nursing home level of care requirement for the LTC program, to be eligible for the MMA program.

The LTC program offers similar services to those offered under the PAC waiver. Some services will not be available, such as massage therapy, but other services available under the LTC program will replace those services.[29]

Adult Cystic Fibrosis Waiver Consolidation

The bill transfers approximately 140 individuals from the ACF waiver to the LTC program.

The bill amends CARES screening requirements to include "hospital level of care" for individuals diagnosed with cystic fibrosis. Currently, to meet LTC eligibility requirements, CARES must determine an individual requires "nursing facility care." This change will allow those individuals diagnosed with cystic fibrosis who do not meet the nursing facility level of care requirement to be eligible for the LTC program.

The LTC program offers similar services to those offered under the ACF waiver, but certain services are not available, such as nutritional supplements and the amount of sterile saline needed by individuals with ACF. AHCA will require LTC program plans to cover over-the-counter benefits to fill the gap in available services.[30]

Traumatic Brain Injury and Spinal Cord Injury Waiver

The bill transfers approximately 350 individuals from the TB/SCI waiver to the LTC program, and 350 individuals from the TB/SCI waiver waitlist to the LTC program waitlist. It is likely those individuals transferred onto the LTC waitlist will transition into the LTC program faster than they would have moved into the TB/SCI waiver due to their high level of acuity and the large number of people enrolled per year from the waitlist into the LTC program.

The LTC program offers services similar to those available through the TB/SCI waiver and expanded benefits will be available to individuals who transfer.

Medication Therapy Management Program

The bill removes the requirement for AHCA to operate a prescription drug management program, and ends the MTM program. Approximately 50 individuals will be impacted. Most Medicaid eligible individuals are already enrolled in the MMA or LTC programs. There are very few individuals eligible for the MTM program that do not otherwise have coverage in the SMMC program and enrolling those who are eligible in the MTM would duplicate services. The evaluation component of the MTM has become less reliable and not statistically significant due to the low participation numbers.[31]

AHCA uses the MTM program to satisfy a federally required research and demonstration component of another Medicaid waiver, the MEDS-AD waiver.[32] In the absence of the MTM program, AHCA will use

[29] Supra, FN 19 at pg. 4.
[30] Supra, FN 19 at pg. 5.
[31] Supra, FN 19 at pg. 6.
[32] The MEDS-AD waiver is another Section 1115 demonstration waiver which serves elderly or disabled individuals with incomes at or below 88% of the Federal Poverty Level and is designed to prevent premature institutionalization by providing access to health care services and medication therapy management. The waiver is limited to those individuals in hospice, home and community based services, or institutional care services that are not eligible for Medicare. See Agency for Health Care Administration, *Florida MEDS-AD Waiver Annual Report, Demonstration Year 9*, available at https://ahca.myflorida.com/medicaid/MEDS-AD/docs/FINAL_MEDS-AD_ANNUAL_RPT-DY9_Jan-Dec_2014.pdf (last accessed February 28, 2017).

its current authority under the MMA program Section 1115 waiver to comply with the research and demonstration requirement of the MEDS-AD waiver.[33]

The bill also deletes s. 409.906(13)(b), F.S., a section of law that allows AHCA to consolidate certain waiver programs that will become obsolete upon passage of the bill.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.904, F.S., relating to optional payments for eligible persons.
Section 2: Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 3: Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.
Section 4: Amends s. 409.979, F.S., relating to eligibility.
Section 5: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will require a transfer of General Revenue funds from DOH to AHCA relating to the TB/SCI waiver in the amount of $1,976,544. The bill will require a transfer of General Revenue funds from DOH to AHCA related to the ACF waiver in the amount of $474,206.

   Additionally, the bill will require AHCA to internally transfer General Revenue of $1,668,324 between budget categories to transfer the PAC waiver to the LTC program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

DOH has worked with AHCA related to the transfer of General Revenue and has not identified any issues with the transfer of General Revenue funds for this purpose.[34]

[33] Supra, FN 19 at pg. 6. AHCA uses this authority to satisfy similar requirements for the Healthy Start and Hemophilia programs.
[34] Email from Paul Runk, Director of Legislative Planning, Department of Health, RE: HB 619, (February 28, 2017)(on file with Health Innovation Subcommittee staff).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2017, the Health Innovation Subcommittee adopted an amendment to HB 619. The amendment made a technical change, removing the unnecessary phrase "or its designee" in reference to certain action taken by AHCA.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

A bill to be entitled

An act relating to consolidation of Medicaid waiver programs; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain persons with AIDS; amending s. 409.906, F.S.; deleting a provision relating to consolidation of waiver services made obsolete by changes made by the act; amending s. 409.912, F.S.; eliminating a prescription drug management program operated by the Agency for Health Care Administration; amending s. 409.979, F.S.; revising eligibility criteria for certain long-term care services; providing for the transition of certain home and community-based services waiver participants into long-term care managed care programs; providing for the termination of certain programs by a specified date after such transition is complete; providing an effective date.

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

Section 1. Subsection (11) is added to section 409.904, Florida Statutes, to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on

behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(11) Subject to federal waiver approval, a person diagnosed with acquired immune deficiency syndrome (AIDS), who has an AIDS-related opportunistic infection and is at risk of hospitalization as determined by the agency, and whose income is at or below 300 percent of the federal benefit rate.

Section 2. Paragraph (b) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or

number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

~~(b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of the need for including a particular service type in a particular waiver. The agency is authorized to seek a Medicaid state plan amendment or federal waiver approval to implement this policy.~~

Section 3. Paragraph (a) of subsection (8) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are

effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy

management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network.

The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(8)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the

agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to,

comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing

practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment

of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

8. The agency shall expand home delivery of pharmacy

products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

10.a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid

behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to

promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

~~11. The agency shall implement a Medicaid prescription drug management system.~~

~~a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.~~

~~b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:~~

~~(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.~~

~~(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.~~

~~(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.~~

~~(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.~~

11.~~12.~~ The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

12.~~13.~~ The agency may specify the preferred daily dosing

form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

13.~~14.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

14.~~15.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may

preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

15.~~16.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical

alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

16.~~17.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be

reused.

Section 4. Subsections (1) and (2) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:

1. Nursing facility care as defined in s. 409.985(3); or

2. Hospital level of care for individuals diagnosed with cystic fibrosis.

(2) ENROLLMENT OFFERS.—Subject to the availability of funds, the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization. Before making enrollment offers, the agency and the Department of Elderly Affairs shall determine that sufficient funds exist to support additional enrollment into plans.

(a) A Medicaid recipient enrolled in one of the following

Medicaid home and community-based service waiver programs is eligible to participate in the long-term care managed care program when all eligibility requirements established in subsection (1) are met and shall be transitioned into the long-term care managed care program by January 1, 2018:

1. Traumatic Brain and Spinal Cord Injury Waiver.

2. Adult Cystic Fibrosis Waiver.

3. Project AIDS Care Waiver.

(b) The agency shall seek federal approval to terminate the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver once all eligible Medicaid recipients have transitioned into the long-term care managed care program.

Section 5. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 749 Adoption Benefits
SPONSOR(S): Children, Families & Seniors Subcommittee, Combee
TIED BILLS: **IDEN./SIM. BILLS:** SB 780

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N, As CS	Roth	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In Florida, the Department of Children and Families (DCF) provides child welfare services. Statute requires child welfare services, including adoption services, to be delivered through community-based care lead agencies contracted by DCF.

Adoption is a method of achieving permanency for children who have suffered abuse, neglect, or abandonment and who are unable to be reunified with their parents.

In 2015, the Legislature reestablished an adoption benefit program within DCF for state employees who adopt children from the foster care system. Qualifying adoptive employees receive a one-time benefit of $10,000 for the adoption of a child with special needs as described in s. 409.166(2)(a)2., F.S, and $5,000 for the adoption of a child who does not have such needs.

A "qualifying adoptive employee" includes those individuals who are regular (not temporary) employees, either full- or part-time, of a state agency, which is defined to include:

- A branch, department, or agency of state government for which the Chief Financial Officer processes payroll requisitions;
- A state university or Florida College system institution as defined in s. 1000.21, F.S.;
- A school district unit as defined in s. 1000.30, F.S.;
- A water management district as defined in 373.019, F.S.; and
- The Florida School for the Deaf and Blind (limited to instructional personnel as defined in 1012.01, F.S.).

In order for an adoptive parent to qualify for the adoption benefit program for state employees, the adoptive parent must meet the requirements set out in statute at the time the adoption takes place.

The bill amends the definition of "qualifying adoptive employee" in s. 409.1664, F.S., to include employees of charter schools granted charter status pursuant to s. 1002.33, F.S., and the Florida Virtual School (FLVS), established under s. 1002.37, F.S. This allows these employees to qualify to receive the incentive monetary benefit for adopting a child from the child welfare system, provided funds are available and other requirements of rule and law are met. The bill makes other technical changes to incorporate the broadened eligibility.

Additionally, the bill creates a clause to ensure that charter or FLVS employees who were employees of a charter school/FLVS on or after July 1, 2015, and adopted a child from DCF during that time may still apply for the monetary benefit.

The program currently has a $2,750,000 recurring general revenue appropriation. Funding is accessed on a first come, first serve basis.

The bill has an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Child Welfare System Adoptions

In Florida, the Department of Children and Families (DCF) provides child welfare services.[1] Statute requires child welfare services, including adoption services, to be delivered through community-based care (CBC) lead agencies contracted by DCF.[2] For example, CBC's provide pre- and post-adoption services and administer maintenance adoption subsidies which provide ongoing financial support for children adopted from the foster care system.

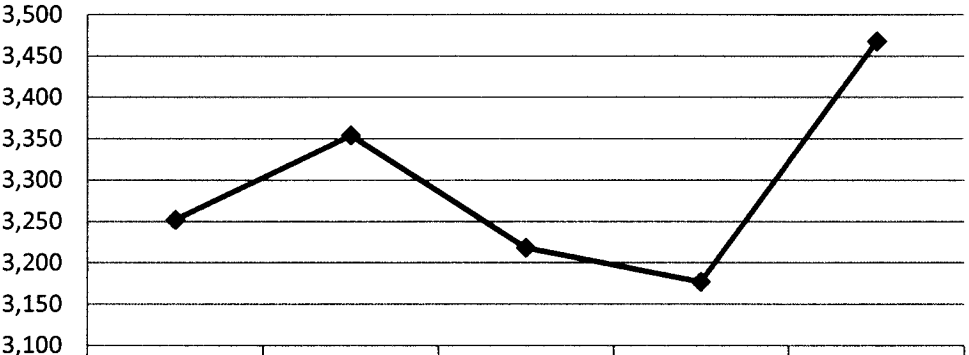
Adoption is a method of achieving permanency for children who have suffered abuse, neglect, or abandonment and who are unable to be reunified with their parents. Research indicates that children generally have better outcomes through adoption than through placement in long-term foster care.[3]

To become a licensed adoptive parent, an individual or couple must complete a licensing study class and complete a homestudy.[4] The typical time frame is less than nine months for the entire process, and there is no cost to adopt a child from the child welfare system through a CBC.[5]

Statistics on Florida Foster Care Adoption

During FY 2015-2016, 3,468 adoptions of children within the child welfare system were finalized in Florida. Over the last 5 federal fiscal years, the number of finalized adoptions in Florida has ranged from 3,177 to 3,468 annually.[6]

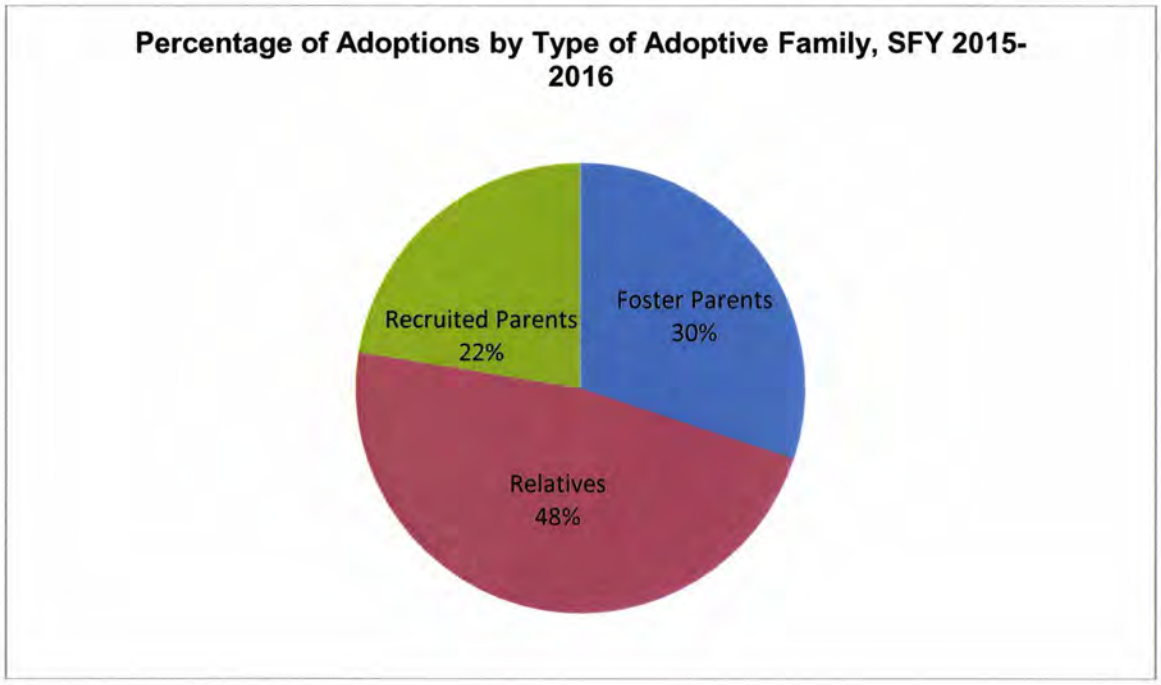
Number of Foster Child Adoptions in Florida



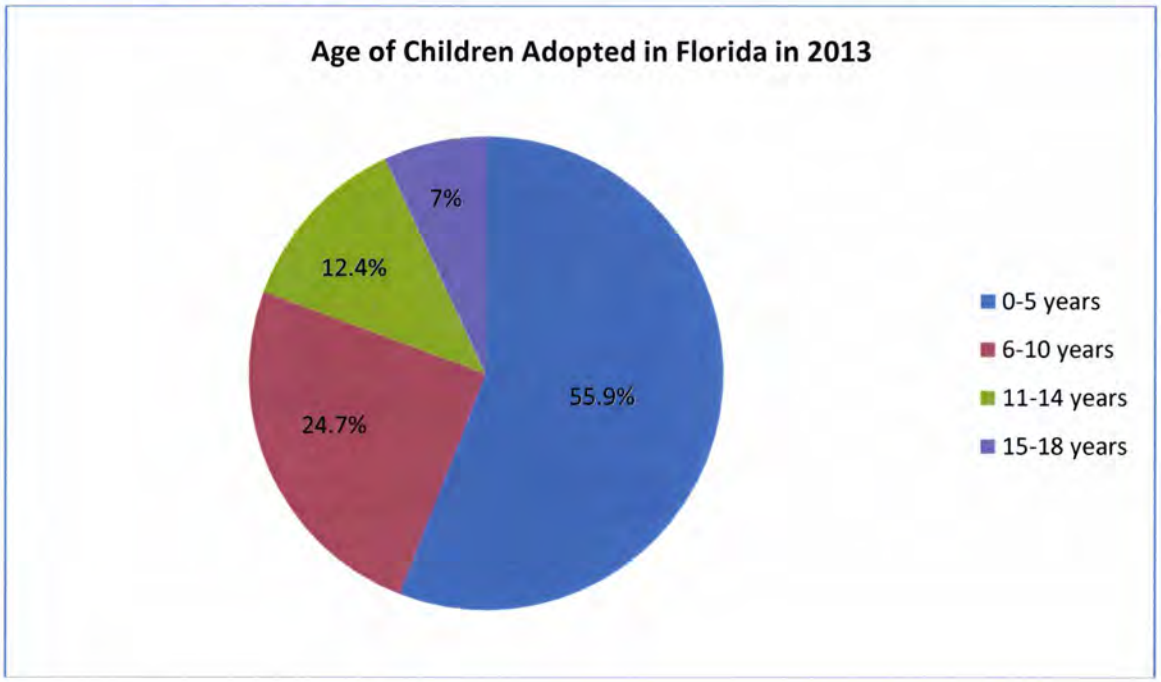
	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Number of Foster Child Adoptions in Florida	3,252	3,354	3,218	3,177	3,468

[1] S. 20.19(4)(a)3., F.S
[2] S. 409.986(1), F.S
[3] Evan B. Donaldson Adoption Institute, *Keeping the Promise: Critical Need for Post-Adoption Services to Enable Children and Families to Succeed*, Oct. 2010, p. 8.
[4] Department of Children and Families, *How Do I Become A Foster Parent?*, 2014, available at http://www.myflfamilies.com/service-programs/foster-care/how-do-I (last viewed March 6, 2017).
[5] Department of Children and Families, *Frequently Asked Questions*, 2015, available at http://www.adoptflorida.org/faq.shtml (last viewed March 6, 2017).
[6] DCF Adoption Incentive Annual Report, *Total Adoptions and the Number of Families who Adopted 1 or More Children by State Fiscal Year*, Appendix A, November 2016, available at http://www.dcf.state.fl.us/programs/childwelfare/docs/2016LMRs/Adoption%20Incentive%20Annual%20Rpt%20plus%20attachments.pdf (last viewed March 3, 2017).

The vast majority of children adopted in FY 2015-16 were adopted by either relatives (47.50%) or foster parents (30.08%). Recruited parents comprised 22.42% of adoptions.[7]



Younger children in the child welfare system tend to be adopted more often than older children.[8, 9]



[7] Office of Adoption and Child Protection, *2016 Annual Report*, January 2017, p. 55.
[8] Supra, FN 7, at p. 50.
[9] Children's Bureau, *Child Welfare Outcomes Report Data 2013, Florida, E.*, available at http://cwoutcomes.acf.hhs.gov/data/output/florida.html, (last viewed March 7, 2017).

Currently in Florida, there are approximately 14,000 children in foster care. As of June 2015, DCF reported there were 5,288 children with a primary goal of adoption,[10] and approximately 750 children are waiting for permanent placement without identified families.[11] Of the almost 800 children in Florida waiting to be adopted, older children (especially teenagers) and sibling groups are likely to wait the longest for an adoptive family. About one-fifth of the children waiting to be adopted are teenagers, many of whom are part of sibling groups that include younger children. Nearly half the children waiting to be adopted are between the ages of six and twelve, while a third are under six.[12]

State Employee Adoption Benefit

Between 2000 and 2010, Florida offered an adoption benefit to state employees.[13] The program provided a one-time cash benefit to employees of the state or a water management district who adopted a child. Qualifying employees adopting a child defined as a "special-needs child" under s. 409.166, F.S., were eligible to receive a monetary benefit of $10,000 per child; qualifying employees adopting a child other than a special-needs child were eligible to receive a monetary benefit in the amount of $5,000 per child.[14] This program also authorized the benefit for private and foreign adoptions.

The law was amended in 2001 to restrict the program to state employees who adopted a child from the foster care system.[15] The benefit program was expanded in 2007 to include county school district employees, community college and university employees, and instructional personnel employed by the Florida School for the Deaf and the Blind as employees eligible to receive the benefit. The Legislature also transferred the program from the Department of Management Services (DMS) to DCF.[16] The program was repealed in 2010.[17]

Total appropriations for the program for years 2000–2005 were $3,063,687, and 300 of 602 eligible adoptions were funded.[18] For example, in 2004, the approximately $1.8 million appropriation was inadequate to fund all 243 eligible applications, and only 179 were funded; while in 2005, $888,000 was appropriated, and only 89 of 167 eligible applications were funded.

In 2015, the Legislature reestablished the adoption benefit program[19] for state employees who adopt children from the foster care system beginning on July 1, 2015. Adoptive employees may receive a one-time benefit of $10,000 for the adoption of a child with special needs as described in s. 409.166(2)(a)2., F.S, and $5,000 for the adoption of a child who does not have such needs.[20]

For purposes of adoption through the child welfare system, a "special needs" child is defined in s. 409.166(2), F.S. as:

- A child whose permanent custody has been awarded to DCF or a licensed child-placing agency; and
- Who has established significant emotional ties with foster parents or is not likely to be adopted because he or she is:

[10] Supra, FN 7, at p. 51.
[11] AdoptUSKids, *Florida Foster Care and Adoption Guidelines*, available at http://www.adoptuskids.org/adoption-and-foster-care/how-to-adopt-and-foster/state-information/florida#children (last viewed February 24, 2017).
[12] DCF, *Florida's Adoption Information Guide: Adoption –What to Know*, available at http://www.adoptflorida.com/information-guide.htm#know (last viewed February 24, 2017).
[13] The term "employee of the state' is not defined in s. 110.152, F.S. (2000).
[14] S. 110.152, F.S. (2000).
[15] S. 110.152, F.S. (2001).
[16] S. 409.1663, F.S. (2007).
[17] Ch. 2010-158, Laws of Fla.
[18] Florida House of Representatives, Staff Analysis, CS/HB 803 (2007).
[19] 65C-16.021 F.A.C. outlines the procedure for applying for the adoption benefits during the open enrollment period between the first business day of March and the last business day of April.
[20] S. 409.1664, F.S. (2015).

    - Eight years of age or older;
    - Developmentally disabled;
    - Physically or emotionally handicapped;
    - Of black or racially mixed parentage; or
    - A member of a sibling group of any age, provided two or more members of a sibling group remain together for purposes of adoption; and
- For whom a reasonable but unsuccessful effort has been made to place the child without providing a maintenance subsidy, except when the child is being adopted by the child's foster parents or relative caregivers.

In order for an adoptive parent to qualify for the adoption benefit program for state employees, he or she must meet the statutory requirements at the time the adoption takes place. A "qualifying adoptive employee" includes those individuals who are regular (not temporary) employees, either full- or part-time, of:

- A branch, department, or agency of state government for which the Chief Financial Officer processes payroll requisitions;[21]
- A state university or Florida College System institution as defined in s. 1000.21, F.S.;
- A school district unit as defined in s. 1000.30, F.S.;
- A water management district as defined in s. 373.019, F.S.; and
- The Florida School for the Deaf and Blind (limited to instructional personnel as defined in s. 1012.01, F.S.).[22]

As of June 30, 2016, there are approximately 115,002 state employees for whom the Chief Financial Officer processes payroll requisitions (including all employees for the School of the Deaf and Blind).[23] In addition, as of the Fall 2015 semester, there are approximately 46,630 State University System employees,[24] and approximately 45,294 Florida College System employees.[25] For FY 2016-2017, there are a total of 2,790 Water Management District full time employees (FTE),[26] and as of FY 2015-2016, there are approximately 345,811 school district employees in Florida.[27] This is a total of approximately 555,527 persons who may potentially apply for the adoption benefits for state employees.

Benefits are provided on a first-come, first-served, basis, limited by the amount of the appropriation each year. In FY 2015-2016, the first year of the reinstated program, 139 employees were approved for a total of $1.3 million in incentives awarded of an appropriated amount of $3 million.[28] The Legislature

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[21] Email from BG Murphy, Deputy Legislative Affairs Director, Office of the Chief Financial Officer, RE: questions regarding HB 749 (March 3, 2017), on file with the Children, Families, and Seniors Subcommittee staff. The office of the Chief Financial Officer processes payroll for the following agencies: Legislature, Auditor General, Judicial Administration, State Courts Administration, Governor's Office, Department of Lottery, Department of Environmental Protection, Department of Economic Opportunity, Legal Affairs, Department of Agriculture, Department of Financial Services, Department of State, Department of Education, School for the Deaf and the Blind, Department of Veterans Affairs, Department of Transportation, Department of Citrus, Department of Children and Families, Public Service Commission, Military Affairs, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities, Agency for Healthcare Administration, Department of Corrections, Florida Department of Law Enforcement, Department of Management Services, Administrative Hearings, State Technology Office, Revenue, Department of Highway Safety & Motor Vehicles, Fish & Wildlife Conservation Commission, Florida Commission on Offender Review, Department of Business and Professional Regulation, and Department of Juvenile Justice.

[22] S. 409.1664(1)(b)-(c), F.S.

[23] Florida Department of Management Services, *2015-2016 State Personnel System Annual Workforce Report*, p. 15, available at http://www.dms.myflorida.com/content/download/130626/811681/2015-16_Annual_Workforce_Report_FINAL_2-22-17.pdf (last viewed March 3, 2017).

[24] Id.

[25] Florida Department of Education, *The Fact Book: Report for the Florida College System*, 2016, p. 6, available at http://fldoe.org/core/fileparse.php/15267/urlt/FactBook2016.pdf (last viewed March 3, 2017).

[26] Email from Jack Furney, Deputy Director for the Office of Water Policy, Florida Department of Environmental Protection, RE: FTE Information (March 6, 2017), on file with the Children, Families, and Seniors Subcommittee staff.

[27] Email from Tanya Cooper, Director of Government Relations, Department of Education, RE: school district employees (March 6, 2017), on file with the Children, Families, and Seniors Subcommittee staff.

[28] Email from Michael Wickersheim, Director of Legislative Affairs, Department of Children and Families, RE: Follow Up (Feb. 14, 2017), on file with the Children, Families, and Seniors Subcommittee staff.

appropriated $4,265,090, in FY 2016-2017, which includes the reappropriated unspent funding from FY 2015-2016.[29] The open enrollment period for FY 2016-2017 began March 1 and runs through April 28.

Charter Schools

Charter schools are authorized by s. 1002.33, F.S., and are tuition-free public schools created through an agreement or "charter" typically between the school and the local district school board. This agreement gives the charter school a measure of expanded freedom relative to traditional public schools in return for a commitment to higher standards of accountability. Since 1996, Florida charter schools have increased parental options in public education and provided innovative learning opportunities for students.[30]

Every charter school has a nonprofit governing board that is responsible for the operation of the school.[31] Section 1002.33(12)(i), F.S., states that, "a charter school shall organize as, or be operated by, a nonprofit organization;" however, "a charter school may be operated by a municipality or other public entity." Therefore, a charter school may be a private or public employer and as a public employer, a charter school may participate in the Florida Retirement System.[32]

During the 2015-16 school year, over 270,000 students were enrolled in 652 charter schools in 46 Florida districts. Many charter schools in Florida have innovative missions. Some charter schools include themed learning approaches focusing on areas such as arts, sciences, and technologies. Other charter schools provide services to special populations such as students at risk of academic failure or students with disabilities.[33]

Charter Schools Overview[34]

School Year	Districts	Charter Schools	Student Enrollment
2011-2012	44	518	179,940
2012-2013	46	578	203,240
2013-2014	45	615	229,428
2014-2015	46	646	251,082
2015-2016	46	652	270,301

Florida's charter schools have become increasingly diverse. In 2015-16, 67% of the students served were minorities. Hispanic students comprised 40% of Florida's charter school enrollment, and 21% were African-American students.[35]

In the 2015-2016 school year there were 26,187 charter school staff, while there are currently 21,408 charter school staff for the 2016-2017 school year.[36]

The Florida Virtual School

The Florida Virtual School (FLVS) is established in s. 1002.37, F.S., for the development and delivery of online and distance learning education. All school districts in Florida offer online schools, programs and/or courses. FLVS teachers must hold Florida teaching certificates, and the curriculum must align with state standards. Full-time FLVS students participate in state assessments, and full-time schools

[29] *Id.*
[30] Florida Department of Education, *Florida's Charter Schools*, October 2016, available at http://www.fldoe.org/core/fileparse.php/18353/urlt/Charter_Oct_2016.pdf (last reviewed February 24, 2017).
[31] Email from Tanya Cooper, Director of Government Relations, Department of Education, RE: questions for HB 749 (March 2, 2017), on file with the Children, Families, and Seniors Subcommittee staff.
[32] S. 1002.33(12)(i), F.S.
[33] Supra, at FN 30.
[34] *Id.*
[35] *Id.*
[36] Email from Tanya Cooper, Director of Government Relations, Department of Education, RE: HB 749 (February 21, 2017), on file with the Children, Families, and Seniors Subcommittee staff.

and programs receive school grades through Florida's accountability system.[37] FLVS is governed by a board of trustees made up of seven members who are appointed by the Governor. The board of trustees is a public agency.[38]

In the 2015-2016 school year, there were 7,705 FLVS full time students.[39] In the 2015-2016 school year, there were 2,099 FLVS staff, while there are currently 2,149 FLVS staff for the 2016-2017 school year.[40]

Effect of Proposed Changes

The bill amends the definition of "qualifying adoptive employee" in s. 409.1664, F.S., to include employees of charter schools granted charter status pursuant to s. 1002.33, F.S., or the Florida Virtual School, established under s. 1002.37, F.S. This will allow these employees to qualify to receive the incentive monetary benefit for adopting a child from the child welfare system, provided funds are available and other requirements of rule and law are met. The bill makes other technical changes to the section to incorporate the bill's expansion of eligibility.

Additionally, the bill creates a retroactive clause to ensure that charter or FLVS employees who were employees of a charter school/FLVS on or after July 1, 2015, and adopted a child from DCF during that time can still apply for the monetary benefit.

The number of persons who can potentially apply for the adoption benefits for state employees will grow by approximately 4 percent.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.1664, F.S., relating to adoption benefits for qualifying adoptive employees of state agencies.
Section 2: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

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[37] Florida Department of Education, *Florida's Public Virtual Education Programs*, November 2016, available at http://www.fldoe.org/core/fileparse.php/5606/urlt/Virtual_Nov_2016.pdf (last reviewed February 24, 2017).
[38] S. 1002.37(2), F.S.
[39] *Id.*
[40] Email from Tanya Cooper, Director of Government Relations, Department of Education, RE: HB 749 (February 21, 2017), on file with the Children, Families, and Seniors Subcommittee staff.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide cash benefits to employees of charter schools or the Florida Virtual School who adopt a qualifying child from the child welfare system provided they meet all requirements and funding is available.

D. FISCAL COMMENTS:

Funding is accessed on a first-come, first served basis. If insufficient funding is available for a qualifying adoptive employee to receive a benefit, he or she will not be provided an incentive but may reapply the next year.

The program received an initial appropriation of $3,000,000 in Fiscal Year 2015-16, of which only $1,469,145 was disbursed for 139 beneficiaries. For Fiscal Year 2016-17, the program received another $2,750,000 appropriation, of which only $15,765 has been disbursed as of February 2017. It's anticipated that existing resources can absorb an increase of eligible beneficiaries pursuant to this bill.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other: None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2017, the Children, Families, and Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The committee substitute differs from the bill as filed by making technical changes to better incorporate charter school and Florida Virtual School employees as incentive beneficiaries, including revising the definition of "qualifying adoptive employee" and the application and disbursement processes. Additionally, the committee substitute differs from the bill as filed by creating a retroactive clause to ensure that charter or Florida Virtual School employees who were such employees on or after July 1, 2015, and adopted a child from DCF during that time, may still apply for the monetary benefit. This analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

A bill to be entitled

An act relating to adoption benefits; amending s. 409.1664, F.S.; revising the definition of the term "qualifying adoptive employee" to include employees of charter schools and the Florida Virtual School for the purpose of extending state employee adoption benefits to such employees; providing for retroactive application; requiring such employees to apply to their school directors to obtain certain monetary benefits; requiring the Chief Financial Officer to transfer funds to charter schools and the Florida Virtual School to enable payments to such employees; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1) and subsections (2), (3), (5), and (7) of section 409.1664, Florida Statutes, are amended to read:

409.1664 Adoption benefits for qualifying adoptive employees of state agencies.—

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

(b) "Qualifying adoptive employee" means a full-time or part-time employee of a state agency, a charter school established under s. 1002.33, or the Florida Virtual School

established under s. 1002.37 who is paid from regular salary appropriations, or otherwise meets his or her ~~the state agency~~ employer's definition of a regular rather than temporary employee, and who adopts a child within the child welfare system pursuant to chapter 63 on or after July 1, 2015. The term includes instructional personnel, as defined in s. 1012.01, who are employed by the Florida School for the Deaf and the Blind.

(2) A qualifying adoptive employee who adopts a child within the child welfare system who has special needs described in s. 409.166(2)(a)2. is eligible to receive a lump-sum monetary benefit in the amount of $10,000 per such child, subject to applicable taxes. A qualifying adoptive employee who adopts a child within the child welfare system who does not have special needs described in s. 409.166(2)(a)2. is eligible to receive a lump-sum monetary benefit in the amount of $5,000 per such child, subject to applicable taxes. A qualifying adoptive employee of a charter school or the Florida Virtual School may retroactively apply for the monetary benefit provided in this subsection if such employee was employed by a charter school or the Florida Virtual School when he or she adopted a child within the child welfare system pursuant to chapter 63 on or after July 1, 2015.

(a) Benefits paid to a qualifying adoptive employee who is a part-time employee must be prorated based on the qualifying adoptive employee's full-time equivalency at the time of

applying for the benefits.

(b) Monetary benefits awarded under this subsection are limited to one award per adopted child within the child welfare system.

(c) The payment of a lump-sum monetary benefit for adopting a child within the child welfare system under this section is subject to a specific appropriation to the department for such purpose.

(3) A qualifying adoptive employee must apply to his or her agency head, or to his or her school director in the case of a qualifying adoptive employee of a charter school or the Florida Virtual School, to obtain the monetary benefit provided in subsection (2). Applications must be on forms approved by the department and must include a certified copy of the final order of adoption naming the applicant as the adoptive parent. Monetary benefits shall be approved on a first-come, first-served basis based upon the date that each fully completed application is received by the department.

(5) Parental leave for a qualifying adoptive employee must be provided in accordance with the personnel policies and procedures of his or her ~~the employee's state agency~~ employer.

(7) The Chief Financial Officer shall disburse a monetary benefit to a qualifying adoptive employee upon the department's submission of a payroll requisition. The Chief Financial Officer shall transfer funds from the department to a state university,

a Florida College System institution, a school district unit, a charter school, the Florida Virtual School, or a water management district, as appropriate, to enable payment to the qualifying adoptive employee through the payroll systems as long as funds are available for such purpose.

Section 2. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 763 Access to Health Care Practitioner Services
SPONSOR(S): Health Quality Subcommittee; Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1432

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 763 incentivizes physicians to provide pro bono health care services to certain low-income individuals and provides an opportunity for physicians from other jurisdictions and retired physicians to provide health services to low-income and medically underserved individuals in this state.

The bill requires Department of Health (DOH) to waive the renewal fee of an allopathic or osteopathic physician who demonstrates to DOH, provision at least 160 hours of pro bono medical services to certain populations within the biennial licensure renewal period. Demonstration of 120 hours of pro bono medical services, gains an exemption from the 40 hours of continuing medical education required for license renewal. A physician is eligible to receive both a waiver of the renewal fee and an exemption from continuing education requirements.

The bill authorizes both the Board of Medicine and the Board of Osteopathic Medicine to issue restricted licenses to physicians not licensed in Florida who contract to practice for 36 months solely in the employ of the state, a federally funded community health center, a migrant health center, a free clinic, or a health provider in a health professional shortage area or medical underserved areas, as designated by the U.S. Department of Health and Human Services. An applicant for a restricted license must hold an active, unencumbered license to practice medicine in another jurisdiction of the United States or Canada and pass a background screening. Each board may issue up to 300 restricted licenses and an unlimited number to physicians who hold active, unencumbered licenses in Canada. Prior to the end of the 36-month contract, the physician must take and pass the appropriate licensing exam to become fully licensed in this state. Breach of contract precludes full licensure.

The bill also creates a registration process for retired physicians to provide volunteer health care services if the physician held an active licensed status to practice and maintained such license in good standing in this state or in another jurisdiction of the United States or Canada for at least 20 years and contracts with a health care provider to provide free, volunteer health care services to indigent persons or medically underserved populations in a health professional shortage area or medically underserved area. Such a physician must work under the supervision of a nonretired physician who holds an active, unencumbered license, only provide medical services of the type and within the specialty performed by the physician prior to retirement, and does not perform surgery or prescribe controlled substances. These physicians are exempt from any application, licensure, and unlicensed activity fees. Registration must be renewed biennially to demonstrate compliance with registration requirements.

The "Access to Health Care Act" (Act) was enacted in 1992 to encourage health care providers to provide care to low-income persons. The bill redefines low-income persons to include individuals that do not have health insurance and have a family income that does not exceed 400 percent of the federal poverty level, rather than the 200 percent in current law.

The bill may have an indeterminate positive impact and an indeterminate negative fiscal impact on DOH (see fiscal impact on state government). Current department resources are sufficient to absorb added workload. The bill will have no impact on local governments.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Licensure and Regulation of Physicians

Allopathic Physicians

Chapter 458, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Medicine (allopathic board) in conjunction the Department of Health (DOH). The chapter provides, among other things, licensure requirements by examination for medical school graduates and licensure by endorsement requirements.

Allopathic Licensure by Examination

An individual seeking to be licensed by examination as an allopathic physician, must meet the following requirements:[1]

- Pay an application fee;[2]
- Be at least 21 years of age;
- Be of good moral character;
- Has not committed an act or offense that would constitute the basis for disciplining a physician, pursuant to s. 458.331, F.S.;
- Complete 2 years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry prior to entering medical school;
- Meets one of the following medical education and postgraduate training requirements:
  - Is a graduate of an allopathic medical school recognized and approved by an accrediting agency recognized by the U.S. Office of Education or recognized by an appropriate governmental body of a U.S. territorial jurisdiction, and has completed at least one year of approved residency training;
  - Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to statute as meeting the standards required to accredit U.S. medical schools, and has completed at least one year of approved residency training; or
  - Is a graduate of an allopathic foreign medical school that has not been certified pursuant to statute; has an active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG),[3] has passed that commission's examination; and has completed an approved residency or fellowship of at least 2 years in one specialty area;
- Has submitted to a background screening by the DOH; and
- Has obtained a passing score on:
  - The United States Medical Licensing Examination (USMLE);

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[1] Section 458.311(1), F.S.

[2] Pursuant to r. 64B8-3.002(5), F.A.C., the application fee for a person desiring to be licensed as a physician by examination is $500. The applicant must pay an initial license fee of $429. Section 766.314(4), F.S., assesses a fee to be paid with at time of an initial license to finance the Florida Birth-Related Neurological Injury Compensation Plan. The current assessment amount is $250 for most practitioners and $5,000 for obstetricians. If a practitioner dispenses medicinal drugs, an additional fee of $100 must be paid at the time of licensure.

[3] A graduate of a foreign medical school does not need to present an ECFMG certification or pass its exam if the graduate received his or bachelor's degree from an accredited U.S. college or university, studied at a medical school recognized by the World Health Organization, and has completed all but the internship or social service requirements, has passed parts I and II of the National Board Medical Examiners licensing examination or the ECFMG equivalent examination. (Section 458.311, F.S.)

- A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or
- The Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX), if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the United States or Canada, and has practiced for a period of at least 10 years.

Allopathic Licensure by Endorsement

An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida.[4] The applicant must meet the same requirements for licensure by examination. To qualify for licensure by endorsement, the applicant must also submit evidence of the licensed active practice of medicine in another jurisdiction for at least 2 of the preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure.

When the allopathic board determines that any applicant for licensure by endorsement has failed to meet, to the allopathic board's satisfaction, each of the appropriate requirements for licensure by endorsement, it may enter an order requiring one or more of the following terms:

- Refusal to certify to the DOH an application for licensure, certification, or registration;
- Certification to the DOH of an application for licensure, certification, or registration with restrictions on the scope of practice of the licensee; or
- Certification to the DOH of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the allopathic board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician.

Allopathic License Renewal

Physician licenses are renewed biennially. The current fee for the timely renewal of a license is $389; this fee also applies to restricted licenses and temporary certificates for practice in areas of critical need.[5] However, if a physician holding a restricted license or temporary certificate for practice in areas of critical need submits a notarized statement from his or her employer stating that the physician will not receive monetary compensation for the provision of medical services, the renewal fees are waived.[6]

Within each biennial licensure renewal period, a physician must complete 40 hours of continuing medical education (CME) courses approved by the allopathic board. As a part of the 40 hours of CME, a licensee must also complete the following:

- A two-hour course regarding domestic violence every third biennial;[7]
- A one-hour course addressing the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome no later than upon the first biennial licensure renewal;[8] and
- Two hours of CME relating to the prevention of medical errors.[9]

[4] Section 458.313, F.S.
[5] Rule 64B8-3.003, F.A.C. If a practitioner dispenses medicinal drugs, an additional fee of $100 must be paid at the time of renewal.
[6] Id.
[7] Section 456.031, F.S.
[8] Section 456.033, F.S.
[9] Section 456.013(7), F.S.

The allopathic board authorizes up to 5 hours of the required CME hours to be fulfilled by the performance of pro bono services to indigent or underserved persons or in areas of critical need.[10] The allopathic board has approved as pro bono service sites, federally funded community and migrant health centers, volunteer health care provider programs contracted to provide uncompensated care with DOH, and DOH. If pro bono services are to be provided to any other entity, the licensee must obtain prior approval for such services to apply against the CME requirement.

DOH may not renew a license until a licensee complies with all CME requirements.[11] The allopathic board may also take action against a license for failure to comply with CME requirements.

Osteopathic Physicians

Chapter 459, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine (osteopathic board) in conjunction the Department of Health (DOH). The chapter provides, among other things, general licensure requirements, including by examination for medical school graduates and licensure by endorsement requirements.

Osteopathic General Licensure

An individual seeking to be licensed as an osteopathic physician must meet the following requirements:[12]

- Pay an application fee;[13]
- Be at least 21 years of age;
- Be of good moral character;
- Complete at least 3 years of preprofessional post-secondary education;
- Has not committed, or be under investigation in any jurisdiction for, an act or offense that would constitute the basis for disciplining an osteopathic physician, unless the osteopathic board determines such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;
- Has not had an application for a license to practice osteopathic medicine denied or a license to practice osteopathic medicine revoked, suspended, or otherwise acted against by the licensing authority in any jurisdiction;
- Has not received less than a satisfactory evaluation from an internship, residency, or fellowship training program;
- Has submitted to a background screening by the DOH;
- Is a graduate of a medical college recognized and approved by the American Osteopathic Association;
- Successfully completes a resident internship of at least 12 months in a hospital approved by the Board of Trustees of the American Osteopathic Association or any other internship approved by the osteopathic board; and
- Obtains a passing score, as established by rule of the osteopathic board, on the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the osteopathic board, no more than five years prior to applying for licensure.[14]

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[10] Rule 64B8-13.005(9), F.A.C. Indigency is persons of low-income (no greater than 150 percent of the federal poverty level) or uninsured persons.
[11] Section 456.031, F.S.
[12] Section 459.0055(1), F.S.
[13] Pursuant to r. 64B15-10.002, F.A.C., the application fee for a person desiring to be licensed as an osteopathic physician by examination is $200. The applicant must pay an initial license fee of $305. Section 766.314(4), F.S., assesses a fee to be paid with at time of an initial license to finance the Florida Birth-Related Neurological Injury Compensation Plan. The current assessment amount is $250.
[14] However, if an applicant has been actively licensed in another state, the initial licensure in the other state must have occurred no more than five years after the applicant obtained the passing score on the licensure examination.

Osteopathic Licensure by Endorsement

If an applicant for a license to practice osteopathic medicine is licensed in another state, the applicant must have actively practiced osteopathic medicine within the two years prior to applying for licensure in this state. If it has been more than two years since the active practice of osteopathic medicine and more than two years since completion of a resident internship, residency, or fellowship and if the osteopathic board determines that the disruption in practice has adversely affected the osteopathic physician's present ability to practice, the osteopathic board may:

- Deny the application;
- Issue the license with reasonable restrictions or conditions; or
- Issue the license upon receipt of documentation confirming the applicant has met any reasonable conditions of the osteopathic board.

Osteopathic License Renewal

Osteopathic physician licenses are renewed biennially. The current fee for the timely renewal of a license is $429; this fee also applies to restricted licenses and temporary certificates for practice in areas of critical need.[15] However, if an osteopathic physician holding a restricted license or temporary certificate for practice in areas of critical need submits a notarized statement from his or her employer stating that the physician will not receive monetary compensation for the provision of medical services, the renewal fees are waived.[16]

Within each biennial licensure renewal period, an osteopathic physician must complete 40 hours of continuing medical education (CME) courses approved by the osteopathic board. As a part of the 40 hours of CME, a licensee must also complete the following:

- A two-hour course regarding domestic violence every third biennial;[17]
- A one-hour course addressing the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome no later than upon the first biennial licensure renewal;[18]
- Two hours of CME relating to the prevention of medical errors;[19]
- A one-hour course on profession and medical ethics education; and
- A one-hour course on the federal and state laws related to the prescribing of controlled substances.[20]

The osteopathic board authorizes up to 10 hours of the required CME hours to be fulfilled by the performance of pro bono medical services to indigent or underserved persons or in areas of critical need.[21] The osteopathic board has approved federally-funded community and migrant health centers, volunteer health care provider programs contracted to provide uncompensated care with DOH, and DOH as pro bono sites. If pro bono services are to be provided to any other entity, the licensee must obtain prior approval for such services to apply to the CME requirement.

DOH may not renew a license until a licensee complies with all CME requirements.[22] The osteopathic board may also take action against a license for failure to comply with CME requirements.

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[15] Rule 64B8-3.003, F.A.C. If a practitioner dispenses medicinal drugs, an additional fee of $100 must be paid at the time of renewal.
[16] Id.
[17] Section 456.031, F.S.
[18] Section 456.033, F.S.
[19] Section 456.013(7), F.S.
[20] Rule 64B15-13.001, F.A.C.
[21] Rule 64B15-13.005, F.A.C. Indigency is persons of low-income (no greater than 150 percent of the federal poverty level) or uninsured persons.
[22] Section 456.031, F.S.

Financial Responsibility

Both allopathic and osteopathic physicians must carry malpractice insurance or demonstrate proof of financial responsibility as a condition of licensure or prior renewal of licensure. A physician may meet this requirement by:

- Maintaining financial liability coverage in an amount of at least $100,000 per claim, with a minimum annual aggregate of at least $300,000 if the licensee does not have hospital privileges;
- Maintaining financial liability coverage in an amount of at least $250,000 per claim, with a minimum annual aggregate of at least $750,000 if the licensee does have hospital privileges;
- Maintaining an unexpired, irrevocable letter of credit or an escrow account in an amount of at least $100,000 per claim, with a minimum aggregate availability of at least $300,000 if the licensee does not have hospital privileges;
- Maintaining an unexpired, irrevocable letter of credit or an escrow account in an amount of at least $250,000 per claim, with a minimum aggregate availability of at least $750,000 if the licensee does have hospital privileges; or
- Not obtaining malpractice insurance or demonstrating financial ability but agreeing to satisfy any adverse judgments and prominently posting a notice in the reception area to notify all patients of such decision.[23]

Physician Licensure for Volunteer and Low-Income Practice

Allopathic Restricted Licenses

Current law authorizes the allopathic board to issue restricted licenses to practice medicine in this state, without examination, for physicians who contracts to practice for 24 months solely in the employ of the state or a federally funded community health center or migrant health center. An applicant for a restricted license must also:

- Meet the requirements for licensure by examination; and
- Have actively practiced medicine in another jurisdiction for at least two years of the immediately preceding four years or has completed board-approved postgraduate training within the year preceding submission of the application.[24]

A restricted licensee must take and pass the licensure examination prior to completion of the 24-month practice period. A restricted licensee who breaches the terms of his or her contract is prohibited from being licensed as a physician in this state.[25]

The allopathic board may issue up to 100 restricted licenses annually.

Osteopathic Limited Licenses

Current law authorizes the osteopathic board to issue limited licenses to certain osteopathic physicians who will only practice in areas of critical need or in medically underserved areas. Such a limited license may be issued to an individual who:

- Submits the licensure application and required application fee of $100;
- Provides proof that he or she has been licensed to practice osteopathic medicine in any jurisdiction of the United States in good standing for at least 10 years;

[23] Sections 458.320, F.S., and 459.0085, F.S.
[24] Section 458.310, F.S.
[25] Id.

- Has completed at least 40 hours of continuing education within the preceding two year period; and
- Will only practice in the employ of public agencies, nonprofit entities, or agencies or institutions in areas of critical need or in medically underserved areas.[26]

If it has been more than three years since the applicant has actively practiced osteopathic medicine, the full-time director of the local county health department must supervise the applicant for at least six months after issuance of the limited license.

The osteopathic board must review the practice of each physician who holds a limited license at least biennially to ensure that he or she is in compliance with the practice act and rules adopted thereunder.

Temporary Certificate for Practice in Areas of Critical Need

Current law authorizes the boards to issue a temporary certificate to practice in areas of critical need to an allopathic or osteopathic physician who will practice in an area of critical need. An applicant for a temporary certificate must:

- Be actively licensed to practice medicine in any jurisdiction of the U.S.;
- Be employed by or practice in a county health department, correctional facility, Department of Veterans' Affairs clinic, federally-funded community health care center, or any other agency or institution designated by the State Surgeon General and provides health care to underserved populations; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's workforce as determined by the Surgeon General.[27]

The allopathic and osteopathic boards are authorized to administer an abbreviated oral examination to determine a physician's competency, but a written examination is not required.[28] If it has been more than three years since the applicant has actively practiced and the board determines the applicant lacks clinical competency, adequate skills, necessary medical knowledge, or sufficient clinical decision-making, the boards may deny the application, issue the temporary certificate with reasonable restrictions, or require the applicant to meet any reasonable conditions of the allopathic or osteopathic board prior to issuing the temporary certificate.

Fees for the temporary certificate for practice in areas of critical need include a $300 application fee and $429 initial licensure fee; however, these fees may be waived if the individual is not compensated for his or her practice.[29] The temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[30] However, the allopathic and osteopathic boards must review the temporary certificateholder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder. If noncompliance is found, the allopathic board may revoke or restrict the temporary certificate for practice in areas of critical need.

Florida Volunteer Protection Act

The Florida Volunteer Protection Act (FVPA), s. 768.1355, F.S., limits the civil liability for volunteers. Under the FVPA, any person who volunteers to perform any service for any nonprofit organization, without compensation from the nonprofit organization, regardless of whether the person is receiving compensation from another source, is an agent of the nonprofit organization when acting within the

[26] Section 459.0075, F.S., and r. 64B15-12.005, F.A.C.
[27] Sections 458.315, and 459.0076, F.S.F.S.
[28] Id.
[29] Rules 64B8-3.003 and 64B15-10.002, F.A.C.
[30] Sections 458.315(3), and 459.0076(3), F.S.

scope of any official duties.[31] The FVPA exempts volunteers from civil liability for any act or omission which results in personal injury or property damage if:

- The volunteer was acting in good faith within the scope of any official duties;
- The volunteer was acting as an ordinary reasonably prudent person would have acted under the same or similar circumstances; and
- The injury or damage was not caused by any wanton or willful misconduct of the volunteer in the performance of such duties.

If a volunteer is determined not to be liable pursuant to these provisions, the nonprofit organization for which the volunteer was performing services when the damages were caused is liable for the damages to the same extent as the nonprofit organization would have been liable if the liability limitation under the Act had not been provided.[32]

Access to Health Care Act

"The Access to Health Care Act" (Act), s. 766.1115, F.S., was enacted in 1992 to encourage health care providers to provide care to low-income persons.[33] Health care providers under the Act include, among others, allopathic and osteopathic physicians.[34] DOH administers the Act through the Volunteer Health Services Program, which works with DOH entities and community and faith-based health care providers to promote access to quality health care for the medically underserved and uninsured in this state.[35]

The Act grants sovereign immunity[36] to health care providers who execute a contract with a governmental contractor[37] and who, as agents of the state, provide volunteer, uncompensated health care services to low-income individuals. These health care providers are considered agents of the state under s.768.28(9), F.S., so have sovereign immunity while acting within the scope of duties required under the Act.[38] Therefore, the state will defend the a health care provider covered under the Act in any

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[31] Section 766.1355, F.S. Compensation does not include reimbursement for actual expenses, a stipend under the Domestic Service Volunteer Act of 1973 (i.e. Americorps and SeniorCorps), or other financial assistance that is valued at less than two-thirds of the federal minimum wage.

[32] Section 768.1355(3), F.S.

[33] Section 766.115, F.S. Low-income persons include a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the DOH who voluntarily chooses to participate in a program offered or approved by the department. A single individual whose annual income does not exceed $24,120 is at 200 percent of the federal poverty level. U.S. Department of Health and Human Services, *HHS Poverty Guidelines for 2017,* (January 26, 2017), *available at* https://aspe.hhs.gov/poverty-guidelines (last visited March 3, 2017).

[34] Section 766.1115(3)(d), F.S.,

[35] DOH, *Volunteer Health Services*, *available at* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/index.html (last visited March 3. 2017).

[36] The legal doctrine of sovereign immunity prevents a government from being sued in its own courts without its consent. According to United States Supreme Court Justice Oliver Wendell Holmes, citing the noted 17th century Hobbes work, *Leviathan*, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends." State governments in the United States, as sovereigns, inherently possess sovereign immunity. Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. When an officer, employee, or agency of the state is sued, the state steps in as the party litigant and defends against the claim. A person may recover no more than $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature. *See* Black's Law Dictionary, 3rd Pocket Edition, 2006; *Kawananakoa v Polyblank*, 205 U.S. 349, 353 (1907); Fla. Jur. 2d, Government Tort Liability, Sec. 1.; Section 768.28, F.S.

[37] A governmental contractor is the DOH, a county health department, a special taxing district having health care responsibilities, or a hospital owned and operated by a governmental entity. Section 766.1115(3)(c), F.S.

[38] Section 766.1115(4), F.S.

action alleging harm or injury, and any recovery would be limited to $200,000 for one incident and a total of $300,000 for all recoveries related to one incident.

A contract under the Act must pertain to volunteer, uncompensated services for which the provider may not receive compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient or any public or private third-party payor for the specific services provided to the low-income recipients covered by the contract.[39]

The Act establishes several contractual requirements for government contractors and health care providers. The contract must require the government contractor to retain the right of dismissal or termination of any health care provider delivering services under the contract[40] and to have access to the patient records of any health care provider delivering services under the contract.[41] The health care provider must, under the contract, report adverse incidents and information on treatment outcomes to the governmental contractor.[42] The governmental contractor or the health care provider must make patient selection and initial referrals.[43] The health care provider is subject to supervision and regular inspection by the governmental contractor.[44]

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of legal actions alleging medical negligence.[45]

In Fiscal Year 2015-2016, 13,195 licensed health care professionals (plus an additional 10,991 clinic staff volunteers) provided 478,511 health care services with a total value of donated goods and services of more than $298 million, under the Act.[46]

Since February 15, 2000, 10 claims have been filed against the Volunteer Health Services Program.[47]

Effect of Proposed Changes

Restricted Licenses to Practice Medicine or Osteopathic Medicine

The bill amends the criteria for the allopathic board to issue restricted licenses to practice allopathic medicine, and authorizes the osteopathic board to issue restricted licenses to practice osteopathic medicine to physicians who contract to practice for 36 months in certain settings. The contract must be for employment by:

- This state;
- A federally funded community health center;
- A migrant health center:
- A free clinic that only delivers medical diagnostic services or nonsurgical medical treatment free of charge to all low-income residents; or
- A health provider in a health professional shortage area or medical underserved areas, as designated by the U.S. Department of Health and Human Services.[48]

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[39] Section 766.1115(3)(a), F.S.
[40] Section 766.1115(4)(a), F.S
[41] Section 766.1115(4)(b), F.S
[42] Section 766.1115(4)(c), F.S
[43] Section 766.1115(4)(d), F.S
[44] Section 766.1115(4)(f), F.S.
[45] Section 766.1115(5), F.S.
[46] DOH, *Volunteer Health Services 2015-2016 Annual Report* (December 2016), *available at* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/Volunteer%20Health%20Services%20Annual%20Report%202016.pdf (last visited March 3, 2017).
[47] Id as A-1. As of April 2016.
[48] As of March 2017, Florida has 655 health professional shortage areas and 128 medically underserved areas. *See* https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx (last visited March 3, 2017) (hover over Florida on the map to get the

To obtain a restricted license, an applicant must:

- Submit a completed application, along with a nonrefundable fee not to exceed $50;
- Be at least 21 years old;
- Be of good moral character;
- Have not committed an act or offense that would constitute the basis for disciplining a physician pursuant to s. 458.331, F.S., or an osteopathic physician pursuant to ch. 459, F.S.;
- Submits to a background screening by DOH; however, a Canadian applicant must also provide the applicable board with a printed or electronic copy of his or her Canadian criminal history records check;
- Submits evidence of the active licensed practice of medicine or osteopathic medicine, as appropriate in another jurisdiction for at least two of the immediately preceding four years, or completion of postgraduate training approved by the appropriate board within the year preceding the filing of an application;
- Enters into a contract to practice for 36 months solely in the employ of the state, a federally funded community health center, a migrant health center, a free clinic, or a health provider in a health professional shortage area or medical underserved areas, as designated by the U.S. Department of Health and Human Services.

Additionally, an osteopathic physicians applying for a restricted license must demonstrate completion of at least three years of preprofessional postsecondary education, that he or she is not under investigation in any jurisdiction that would constitute a violation of the osteopathic medicine practice act, and that he or she has not had an application for a license to practice osteopathic medicine denied or a license to practice osteopathic medicine revoked, suspended, or otherwise acted against, by the licensing authority in any jurisdiction.

Each board may issue no more than 300 restricted licenses; however, the boards may issue an unlimited number of restricted licenses to physicians who hold active unencumbered licenses in Canada.

Prior to the conclusion of the contracted practice period, an allopathic or osteopathic physician must take the appropriate licensure examination to become fully licensed in this state. However, a physician who breaches the terms of the employment contract may not be licensed as a physician in this state.

The bill also repeals the authority of the Board of Medicine to adopt rules related to the criteria for the issuance of restricted licenses. However, both the allopathic and osteopathic boards have broad grants of rulemaking authority to adopt rules implementing statutes related to the licensure and regulation of physicians.[49] Therefore, the boards may adopt any rules necessary to implement the restricted licenses.

The bill maintains current law authorizing limited licenses for osteopathic physicians.

Volunteer Retired Physician Registration

The bill creates a registration program to allow retired physicians to practice medicine under contact with a health care provider to provide free, volunteer health care services to indigent persons or medically underserved populations in a health professional shortage area or medically underserved area as designated by the U.S. Department of Health and Human Services.

The bill authorizes a retired physician to register as a volunteer retired physician if the physician:

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number of health professional shortage areas and click on the State Summary of Medically Underserved Areas/Populations to obtain the number of medically underserved areas).

[49] *See* s. 458.309 and 459.005, F.S.

- Submits an application to the board within two years of changing the license to practice from active status to retired status for an allopathic physician, of if he or submits an application to board no more than six months before the license permanently expires and no later than two years after such expiration for an osteopathic physician;
- Provides proof of active practice medical practice for at least three of the five years immediately preceding the date on which the license changed from active status to retired status for an allopathic physician;
- Has held an active licensed status to practice and maintained such license in good standing in this state or in another jurisdiction or the United States or Canada for at least 20 years;
- Works under the supervision of a nonretired allopathic physician or osteopathic physician, as applicable, who holds an active unencumbered license; and
- Only provides medical services of the type and within the specialty performed by the physician prior to retirement and does not perform surgery or prescribe controlled substances.

DOH must waive application fee, licensure fee, and unlicensed activity fee for retired physicians who qualify for registration under the provisions of the bill. Registration must be renewed biennially to demonstrate compliance with registration requirements. A board may deny, revoke, or impose restrictions or conditions on a registration if there is a violation of the practice act or the core licensing statute (ch. 456, F.S.) A board may also revoke or deny a registration for failure to comply with registration requirements.

Licensure Renewals

The bill requires DOH to waive the licensure renewal fee of an allopathic or osteopathic physician who demonstrates to DOH, in a manner provided by board rule, that he or she has provided at least 160 hours of pro bono medical services to indigent persons or medically underserved populations within the biennial renewal period.

If an allopathic or osteopathic physician provides documentation to DOH that he or she has provided at least 120 hours of pro bono medical services within the biennial licensure period, he or she is exempt from the 40 hours of continuing medical education required for license renewal. This exemption would also apply to any of the specific courses, such as the courses on domestic violence and prevention of medical errors, that are calculated as a part of as a part of the required 40 hours of continuing medical education.

A physician may receive both the waiver of the licensure renewal fee and an exemption from the continuing medical education requirements if the required number of pro bono hours are provided.

Physician Licensure by Examination

Currently, allopathic physicians who hold an active unencumbered license to practice medicine in Canada who have practiced at least 10 years may use a passing score the Special Purpose Examination of the Federation of State Medical Boards of the United States to qualify for licensure in this state. The bill removes the requirement that allopathic physicians licensed in Canada must practice for 10 years to use the Special Purpose Examination of the Federation of State Medical Boards of the United States to qualify for licensure.

Access to Health Care Act

The bill increases the eligibility for services under the Act by amending the definition of low-income to mean a person without health insurance and whose family income does not exceed 400 percent of the federal poverty level, rather than the 200 percent in current law.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.013, F.S., relating to department; general licensing provisions.
Section 2: Amends s. 458.310, F.S., relating to restricted licenses.
Section 3: Creates s. 458.3105, F.S., relating to registration of volunteer retired physicians.
Section 4: Amends s. 458.311, F.S., relating to licensure by examination; requirements; fees.
Section 5: Amends s. 458.319, F.S., relating to renewal of license.
Section 6: Creates s. 459.00751, F.S., relating to restricted licenses.
Section 7: Creates s. 459.00752, F.S., relating to registration of volunteer retired osteopathic physicians.
Section 8: Amends s. 459.008, F.S., relating to renewal of licenses and certificates.
Section 9: Amends s. 766.1115, F.s., relating to health care providers; creation of agency relationship with governmental contractors.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill may have an indeterminate positive fiscal impact on DOH associated with the new application fees for osteopathic physician restricted licenses. It is unknown how many may apply, but is not likely to be significant.

2. Expenditures:

   The bill may have an insignificant, indeterminate negative fiscal impact on DOH associated with the loss of licensure application and renewal fees for those physicians who qualify for the waiver of such fees.

   DOH may experience an insignificant, indeterminate negative fiscal impact for rulemaking activities, and labor costs associated with processing the restricted licenses and registrations authorized under the provisions of the bill. However, current resources are sufficient to absorb such costs.[50]

   DOH may experience an indeterminate, nonrecurring negative fiscal impact for modifications to its Licensing and Enforcement Information Database to accommodate requirements of the bill.[51] It is estimated current resources are sufficient to absorb these costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Physicians performing pro bono medical services may not have to pay licensure renewal fees or pay for continuing education courses.

[50] DOH, "2017 Agency Bill Analysis: House Bill 763," (February 10, 2017), on file with the Health Quality Subcommittee.
[51] Id.

Entities providing continuing education courses may see a drop in enrollment if physicians provide at least 120 hours of pro bono medical services and take advantage of the continuing education exemption.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Both the allopathic and osteopathic boards have broad grants of rulemaking authority to adopt rules under their respective practice acts; therefore, no additional rulemaking authority is needed.[52]

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2017, the Health Quality Subcommittee adopted an amendment that did the following:

- Required a Canadian applicant for a restricted license to submit to a Level II background screening.
- Authorized the boards to deny, revoke, or subject to conditions the registration of a retired physician who violates the core licensure act or the applicable practice act.
- Restored a requirement that Canadian applicants using a specific examination to meet the allopathic medicine licensure requirements to have practiced for at least 10 years.

[52] *See* ss. 458.309 and 459.005, F.S.

A bill to be entitled

An act relating to access to health care practitioner services; amending s. 456.013, F.S.; exempting physicians who provide a certain number of hours of pro bono services from continuing education requirements; amending s. 458.310, F.S.; revising the eligibility criteria for a restricted license; prohibiting licensure if a restricted licensee breaches the terms of an employment contract; creating s. 458.3105, F.S.; establishing a registration program for volunteer retired physicians; providing eligibility criteria for such registration; requiring biennial renewal of registration; authorizing the Department of Health to waive certain fees; authorizing the Board of Medicine to deny, revoke, or impose restrictions or conditions on a registration for certain violations; amending s. 458.311, F.S.; revising the physician licensure criteria applicable to Canadian applicants; amending s. 458.319, F.S.; requiring the department to waive a physician's license renewal fee under certain circumstances; creating s. 459.00751, F.S.; providing legislative intent; authorizing the Board of Osteopathic Medicine to issue a restricted license to qualified applicants; providing eligibility criteria for such license;

prohibiting licensure if a restricted licensee breaches the terms of an employment contract; creating s. 459.00752, F.S.; establishing a registration program for volunteer retired osteopathic physicians; providing eligibility criteria for such registration; requiring biennial renewal of registration; authorizing the Department of Health to waive certain fees; authorizing the Board of Osteopathic Medicine to deny, revoke, or impose restrictions or conditions on a registration for certain violations; amending s. 459.008, F.S.; requiring the department to waive an osteopathic physician's license renewal fee under certain circumstances; amending s. 766.1115, F.S.; revising the definition of the term "low-income" for purposes of the Access to Health Care Act; providing an effective date.

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

Section 1. Subsection (6) of section 456.013, Florida Statutes, is republished, and subsection (9) of that section is amended to read:

456.013 Department; general licensing provisions.—

(6) As a condition of renewal of a license, the Board of Medicine, the Board of Osteopathic Medicine, the Board of

Chiropractic Medicine, and the Board of Podiatric Medicine shall each require licensees which they respectively regulate to periodically demonstrate their professional competency by completing at least 40 hours of continuing education every 2 years. The boards may require by rule that up to 1 hour of the required 40 or more hours be in the area of risk management or cost containment. This provision shall not be construed to limit the number of hours that a licensee may obtain in risk management or cost containment to be credited toward satisfying the 40 or more required hours. This provision shall not be construed to require the boards to impose any requirement on licensees except for the completion of at least 40 hours of continuing education every 2 years. Each of such boards shall determine whether any specific continuing education requirements not otherwise mandated by law shall be mandated and shall approve criteria for, and the content of, any continuing education mandated by such board. Notwithstanding any other provision of law, the board, or the department when there is no board, may approve by rule alternative methods of obtaining continuing education credits in risk management. The alternative methods may include attending a board meeting at which another licensee is disciplined, serving as a volunteer expert witness for the department in a disciplinary case, or serving as a member of a probable cause panel following the expiration of a board member's term. Other boards within the Division of Medical

Quality Assurance, or the department if there is no board, may adopt rules granting continuing education hours in risk management for attending a board meeting at which another licensee is disciplined, for serving as a volunteer expert witness for the department in a disciplinary case, or for serving as a member of a probable cause panel following the expiration of a board member's term.

(9) Any board that currently requires continuing education for renewal of a license, or the department if there is no board, shall adopt rules to establish the criteria for continuing education courses. The rules may provide that up to a maximum of 25 percent of the required continuing education hours can be fulfilled by the performance of pro bono services to the indigent or to underserved populations or in areas of critical need within the state where the licensee practices. However, a physician licensed under chapter 458 or chapter 459 who submits to the department documentation proving that he or she has completed at least 120 hours of pro bono services within a biennial licensure period is exempt from the continuing education requirements established by board rule under subsection (6). The board, or the department if there is no board, must require that any pro bono services be approved in advance in order to receive credit for continuing education under this subsection. The standard for determining indigency shall be that recognized by the Federal Poverty Income

Guidelines produced by the United States Department of Health and Human Services. The rules may provide for approval by the board, or the department if there is no board, that a part of the continuing education hours can be fulfilled by performing research in critical need areas or for training leading to advanced professional certification. The board, or the department if there is no board, may make rules to define underserved and critical need areas. The department shall adopt rules for administering continuing education requirements adopted by the boards or the department if there is no board.

Section 2. Subsections (2) and (3) of section 458.310, Florida Statutes, are amended to read:

458.310 Restricted licenses.—

(2) The board ~~of Medicine~~ may annually~~, by rule, develop criteria and, without examination,~~ issue restricted licenses authorizing the practice of medicine in this state to not more than 300 persons and to an unlimited number of physicians who hold active unencumbered licenses to practice medicine in Canada if such applicants ~~annually to up to 100 persons to practice medicine in this state who~~:

(a) Submit to the department a completed application form and a nonrefundable application fee not to exceed $50;

(b)~~(a)~~ Meet the requirements of s. 458.311(1)(b), (c), (d), and (g). A Canadian applicant must also provide the board with a printed or electronic copy of his or her Canadian

criminal history records check;

(c) ~~(b)~~ Show evidence of the active licensed practice of medicine in another jurisdiction for at least 2 years of the immediately preceding 4 years, or completion of board-approved postgraduate training within the year preceding the filing of an application; and

(d) ~~(c)~~ Enter into a contract to practice for a period of up to 36 ~~24~~ months ~~solely~~ in the employ of the state, ~~or~~ a federally funded community health center, or a migrant health center; a free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income residents; or a health care provider in a health professional shortage area or medically underserved area, designated by the United States Department of Health and Human Services~~, at the current salary level for that position~~. The board may ~~of Medicine shall~~ designate other areas of critical need in the state where these restricted licensees may practice.

(3) Before the end of the contracted ~~24-month~~ practice period, the physician must take and successfully complete the licensure examination under s. 458.311 to become fully licensed in this state.

Section 3. Section 458.3105, Florida Statutes, is created to read:

458.3105 Registration of volunteer retired physicians.—

(1) A physician may register under this section to

practice medicine as a volunteer retired physician if the physician:

(a) Submits an application to the board on a form developed by the department within 2 years after the date on which the physician's license changed from active status to retired status;

(b) Provides proof to the department that the physician actively practiced medicine for at least 3 of the 5 years immediately preceding the date on which his or her license changed from active status to retired status;

(c) Has held an active license to practice medicine and maintained such license in good standing in this state or in at least one other jurisdiction of the United States or Canada for at least 20 years;

(d) Contracts with a health care provider to provide free, volunteer health care services to indigent persons or medically underserved populations in health professional shortage areas or medically underserved areas designated by the United States Department of Health and Human Services;

(e) Works under the supervision of a nonretired physician who holds an active unencumbered license; and

(f) Only provides medical services of the type and within the specialty performed by the physician prior to retirement, and does not perform surgery or prescribe a controlled substance as defined in s. 893.02(4).

(2) The registrant shall apply biennially to the board for renewal of his or her registration by demonstrating to the board compliance with this section.

(3) The department shall waive the application fee, licensure fee, and unlicensed activity fee for qualifying applicants under this section.

(4) The board may deny, revoke, or impose restrictions or conditions on a registration for any violation of this act or chapter 456, or the rules adopted under this act or chapter 456.

(5) The board may deny or revoke registration for noncompliance with this section.

Section 4. Paragraph (h) of subsection (1) of section 458.311, Florida Statutes, is amended to read:

458.311 Licensure by examination; requirements; fees.—

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:

(h) Has obtained a passing score, as established by rule of the board, on the licensure examination of the United States Medical Licensing Examination (USMLE); or a combination of the United States Medical Licensing Examination (USMLE), the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or for the

purpose of examination of any applicant who was licensed on the basis of a state board examination and who is currently licensed in at least one other jurisdiction of the United States ~~or Canada~~, and who has practiced pursuant to such licensure for a period of at least 10 years, or for the purpose of examination of any applicant who holds an active unencumbered license to practice medicine in Canada and who has practiced pursuant to such licensure for a period of at least 10 years, use of the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX) upon receipt of a passing score as established by rule of the board. However, for the purpose of examination of any applicant who was licensed on the basis of a state board examination prior to 1974, who is currently licensed in at least three other jurisdictions of the United States or Canada, and who has practiced pursuant to such licensure for a period of at least 20 years, this paragraph does not apply.

Section 5. Subsection (1) of section 458.319, Florida Statutes, is amended to read:

458.319 Renewal of license.—

(1) The department shall renew a license upon receipt of the renewal application, evidence that the applicant has actively practiced medicine or has been on the active teaching faculty of an accredited medical school for at least 2 years of the immediately preceding 4 years, and a fee not to exceed $500;

provided, however, that if the licensee is either a resident physician, assistant resident physician, fellow, house physician, or intern in an approved postgraduate training program, as defined by the board by rule, the fee shall not exceed $100 per annum. If the licensee demonstrates to the department in a manner set by department rule that he or she has provided at least 160 hours of pro bono medical services to indigent persons or medically underserved populations within the biennial renewal period, the department shall waive the renewal fee. If the licensee has not actively practiced medicine for at least 2 years of the immediately preceding 4 years, the board shall require that the licensee successfully complete a board-approved clinical competency examination prior to renewal of the license. "Actively practiced medicine" means that practice of medicine by physicians, including those employed by any governmental entity in community or public health, as defined by this chapter, including physicians practicing administrative medicine. An applicant for a renewed license must also submit the information required under s. 456.039 to the department on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the Department of Health for the statewide criminal background check of the applicant. The applicant must submit a set of fingerprints to the Department of Health on a form and under procedures specified by the department, along with payment in an

amount equal to the costs incurred by the department for a national criminal background check of the applicant for the initial renewal of his or her license after January 1, 2000. If the applicant fails to submit either the information required under s. 456.039 or a set of fingerprints to the department as required by this section, the department shall issue a notice of noncompliance, and the applicant will be given 30 additional days to comply. If the applicant fails to comply within 30 days after the notice of noncompliance is issued, the department or board, as appropriate, may issue a citation to the applicant and may fine the applicant up to $50 for each day that the applicant is not in compliance with the requirements of s. 456.039. The citation must clearly state that the applicant may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the applicant disputes the matter in the citation, the procedures set forth in s. 456.073 must be followed. However, if the applicant does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. Service of a citation may be made by personal service or certified mail, restricted delivery, to the subject at the applicant's last known address. If an applicant has submitted fingerprints to the department for a national criminal history check upon initial licensure and is renewing his or her license for the first time, then the applicant need only submit

the information and fee required for a statewide criminal history check.

Section 6. Section 459.00751, Florida Statutes, is created to read:

459.00751 Restricted licenses.—

(1) It is the intent of the Legislature to provide medical services to all residents of this state at an affordable cost.

(2) The board may annually issue restricted licenses authorizing the practice of osteopathic medicine in this state to not more than 300 persons and to an unlimited number of osteopathic physicians who hold active unencumbered licenses to practice medicine in Canada if such applicants:

(a) Submit to the department a completed application form and a nonrefundable application fee not to exceed $50;

(b) Meet the requirements of s. 459.0055(1)(b), (c), (d), (e), (f), (g), and (j). A Canadian applicant must also provide the board with a printed or electronic copy of his or her Canadian criminal history records check;

(c) Provide proof to the department that the osteopathic physician has held an active license to practice osteopathic medicine and maintained such license in good standing in this state or in at least one other jurisdiction of the United States or Canada for at least 2 of the immediately preceding 4 years, or completed board-approved postgraduate training within the year immediately preceding the filing of an application; and

(d) Enter into a contract to practice osteopathic medicine for a period of up to 36 months in the employ of the state, a federally funded community health center, or a migrant health center; a free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income residents; or a health care provider in a health professional shortage area or medically underserved area designated by the United States Department of Health and Human Services. The board may designate other areas of critical need in the state where these restricted licensees may practice.

(3) Before the end of the contracted practice period, the osteopathic physician must take and successfully complete the licensure examination under s. 459.0055 to become fully licensed in this state.

(4) If the restricted licensee breaches the terms of the employment contract, he or she may not be licensed as an osteopathic physician in this state under any licensing provisions.

Section 7. Section 459.00752, Florida Statutes, is created to read:

459.00752 Registration of volunteer retired osteopathic physicians.—

(1) An osteopathic physician may register under this section to practice medicine as a volunteer retired osteopathic physician if the osteopathic physician:

(a) Submits an application to the board on a form developed by the department no earlier than 6 months before the date on which the osteopathic physician's license permanently expires and no later than 2 years after such expiration;

(b) Has held an active license to practice osteopathic medicine and maintained such license in good standing in this state or in at least one other jurisdiction of the United States or Canada for at least 20 years;

(c) Contracts with a health care provider to provide free, volunteer health care services to indigent persons or medically underserved populations in health professional shortage areas or medically underserved areas designated by the United States Department of Health and Human Services;

(d) Works under the supervision of a nonretired osteopathic physician who holds an active unencumbered license; and

(e) Only provides medical services of the type and within the specialty performed by the osteopathic physician prior to retirement, and does not perform surgery or prescribe controlled substances as defined in s. 893.02(4).

(2) The registrant shall apply biennially to the board for renewal of his or her registration by demonstrating to the board compliance with this section.

(3) The department shall waive the application fee, licensure fee, and unlicensed activity fee for qualifying

applicants under this section.

(4) The board may deny, revoke, or impose restrictions or conditions on a registration for any violation of this act or chapter 456, or the rules adopted under this act or chapter 456.

(5) The board may deny or revoke registration for noncompliance with this section.

Section 8. Subsection (1) of section 459.008, Florida Statutes, is amended to read:

459.008 Renewal of licenses and certificates.—

(1) The department shall renew a license or certificate upon receipt of the renewal application and fee. If the licensee demonstrates to the department that he or she has provided at least 160 hours of pro bono osteopathic medical services to indigent persons or medically underserved populations within the biennial renewal period, the department shall waive the renewal fee. An applicant for a renewed license must also submit the information required under s. 456.039 to the department on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the department ~~of Health~~ for the statewide criminal background check of the applicant. The applicant must submit a set of fingerprints to the Department of Health on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the department for a national criminal background check of the applicant for the

initial renewal of his or her license after January 1, 2000. If the applicant fails to submit either the information required under s. 456.039 or a set of fingerprints to the department as required by this section, the department shall issue a notice of noncompliance, and the applicant will be given 30 additional days to comply. If the applicant fails to comply within 30 days after the notice of noncompliance is issued, the department or board, as appropriate, may issue a citation to the applicant and may fine the applicant up to $50 for each day that the applicant is not in compliance with the requirements of s. 456.039. The citation must clearly state that the applicant may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the applicant disputes the matter in the citation, the procedures set forth in s. 456.073 must be followed. However, if the applicant does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. Service of a citation may be made by personal service or certified mail, restricted delivery, to the subject at the applicant's last known address. If an applicant has submitted fingerprints to the department for a national criminal history check upon initial licensure and is renewing his or her license for the first time, then the applicant need only submit the information and fee required for a statewide criminal history check.

Section 9. Paragraph (e) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

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

(e) "Low-income" means:

1. A person who is Medicaid-eligible under Florida law;

2. A person who is without health insurance and whose family income does not exceed 400 ~~200~~ percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or

3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

Section 10. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 785 Stroke Centers
SPONSOR(S): Health Quality Subcommittee; Magar and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1406

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N, As CS	Langston	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A stroke is a serious medical condition that occurs when the blood supply to part of the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death. Stroke is one of the leading causes of death in the United States.

The Agency for Health Care Administration (AHCA) establishes criteria for primary and comprehensive stroke centers in Florida. There are 118 Florida hospitals designated as a Primary Stroke Center in 37 counties and 41 Comprehensive Stroke Centers in 16 counties. Additionally, AHCA maintains an inventory of hospitals offering stroke services.

Research indicates that patients receiving care at primary stroke centers have a higher incidence of survival and recovery than those treated in hospitals without this type of specialized care. However, many patients with an acute stroke live in areas without ready access to a primary or comprehensive stroke center; more than half the United States population lived more than an hour away from a stroke center. Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke. A recent study by the American Stroke Association proposed a new designation for hospitals that are not primary stroke centers, but can provide timely, evidence-based care to most patients with an acute stroke. Acute stroke-ready hospitals provide initial diagnostic services, stabilization, emergent care and therapies to patients with an acute stroke who are seen in their emergency department, and would then transfer these patients to a primary or comprehensive stroke center.

The Department of Health (DOH) provides a stroke assessment tool to emergency medical service providers, which must use it or another tool that is substantially similar. DOH sends a list of primary stroke centers and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in Florida anually.

CS/HB 785 amends s. 395.3038, F.S. to include a new level of stroke services entitled acute stroke ready centers and adds them to the list of stroke centers DOH supplies to emergency service providers in the state.

The bill creates a statewide stroke registry. DOH must contract with a recognized medical organization in the state of Florida to establish and maintain the registry and must specify the information to be reported to the registry in rule. These reports will be used to evaluate stroke care system effectiveness, monitor patient outcomes, improve or modify the stroke care systems. The bill requires DOH to develop electronic forms for stroke centers to report the required information to the registry; and post them on its website. The bill grants liability protection from damages and any other relief for any entity that provides information required by the registry.

The bill removes obsolete deadlines for DOH to implement the stroke-triage assessment tool.

The bill has an insignificant negative fiscal impact on AHCA and a negative fiscal impact on DOH due to the contract requirement.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

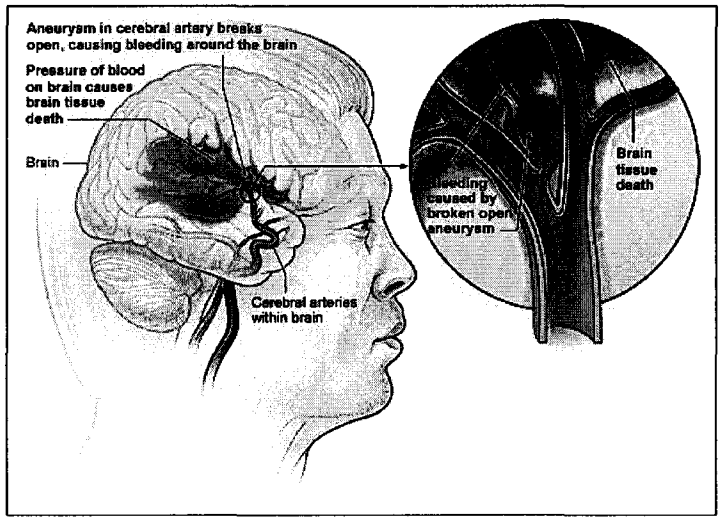
Background

Stroke

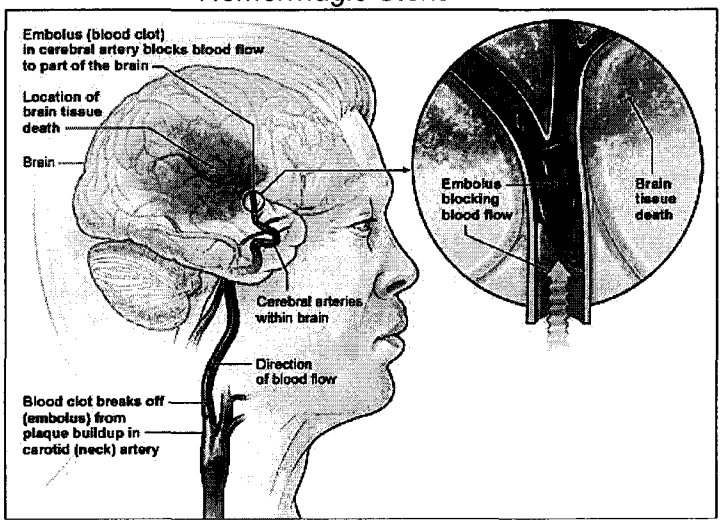
A stroke is a serious medical condition that occurs when the blood supply to part of the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.[1] The brain needs a constant supply of oxygen and nutrients in order to function.[2] Even a brief interruption in blood supply from a stoke can cause problems; brain cells begin to die after just a few minutes without blood or oxygen.[3] Brain cell death causes loss of brain function, including impaired ability with movement, speech, thinking and memory, bowel and bladder, eating, emotional control, and other vital body functions. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death.[4] Stroke is one of the leading causes of death in the United States.[5]

There are two main types of stroke: an ischemic stroke, the more common type, which occurs when an artery that supplies oxygenated blood to the brain becomes blocked; and a hemorrhagic stroke, which occurs if an artery in the brain leaks blood or ruptures.[6]

Ischemic Stroke[7]



Hemorrhagic Stoke[8]



The two types of ischemic stroke are thrombotic and embolic.[9] In a thrombotic stroke, a blood clot, called a thrombus, forms in an artery that supplies blood to the brain.[10] In an embolic stroke, a blood clot or other substance, such as plaque, a fatty material, travels through the bloodstream to an artery in

[1] MAYO CLINIC, *Stroke*, http://www.mayoclinic.org/diseases-conditions/stroke/home/ovc-20117264 (last visited March 2, 2017).
[2] UCLA STROKE CENTER, *What is a Stroke?*, http://stroke.ucla.edu/what-is-a-stroke (last visited March 2, 2017).
[3] Id.
[4] Id.
[5] NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *What Is a Stroke?*, https://www.nhlbi.nih.gov/health/health-topics/topics/stroke (last visited March 2, 2017).
[6] Id.
[7] NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *Types of Stroke*, https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/types (last visited March 2, 2017).
[8] Id.
[9] Id.
[10] Id.

the brain.[11] With both types of ischemic stroke, the blood clot or plaque blocks the flow of oxygenated blood to a portion of the brain.[12]

The two types of hemorrhagic stroke are intracerebral and subarachnoid.[13] In an intracerebral hemorrhage, a blood vessel inside the brain leaks blood or ruptures.[14] In a subarachnoid hemorrhage, a blood vessel on the surface of the brain leaks blood or ruptures; when this happens, bleeding occurs between the inner and middle layers of the membranes that cover the brain.[15] In both types of hemorrhagic stroke, the leaked blood causes swelling of the brain and increased pressure in the skull.[16]

Treatment

Time is of the essence for stroke treatment; medical personnel begin treatment in an ambulance on the way to the emergency room.[17] Treatment for a stroke also depends on how much time has passed since symptoms began and on whether it is ischemic or hemorrhagic.[18] Treatment for an ischemic stroke may include medicines, such as antiplatelet medicines and blood thinners, and medical procedures, but a hemorrhagic stroke may be treated with surgery to find and stop the bleeding.[19] In addition to emergency care to treat the stroke, an individual may also receive treatment to prevent another stroke and rehabilitation to treat the side effects of the stroke.[20] According to the United States Centers for Disease Control and Prevention, research indicates that patients receiving care at primary stroke centers have a higher incidence of survival and recovery than those treated in hospitals without this type of specialized care.[21]

Stroke Centers in Florida

Florida was one of the first four states, in 2004, to enact primary stroke center legislation.[22] Pursuant to s. 395.3038, F.S., the Agency for Health Care Administration (AHCA) establishes criteria for primary and comprehensive stroke centers. There are 118 Florida hospitals designated as primary stroke centers in 37 counties and 41 comprehensive stroke centers in 16 counties.[23]

Primary Stroke Centers

A primary stroke center certification recognizes hospitals that meet standards to support better outcomes for stroke care.[24] Such hospitals must have a dedicated stroke-focused program, be staffed by qualified medical professionals trained in stroke care, and provide individualized care to meet stroke patients' needs based on recommendations of the Brain Attack Coalition and guidelines published by

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[11] Id. The blood clot or other substance traveling through the bloodstream is called an embolus.
[12] Id.
[13] Id.
[14] Id.
[15] Id.
[16] Id.
[17] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Stroke Treatment*, https://www.cdc.gov/stroke/treatments.htm (Last visited March 2, 2017).
[18] NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *How Is a Stroke Treated?*, https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/treatment (last visited March 2, 2017).
[19] Id.
[20] *Supra*, note 17.
[21] Centers for Disease Control and Prevention, A *summary of primary stroke center policy in the United States*, (2011), available at https://www.cdc.gov/dhdsp/pubs/docs/primary_stroke_center_report.pdf (last visited March 2, 2017)
[22] S. 3, ch. 2004-325, Laws of Fla.
[23] Florida Agency for Health Care Administration, Agency Analysis of 2017 House Bill 785, (Feb. 17, 2017) (analysis on file with Health Quality Subcommittee Staff). Although stroke services is dependent upon the availability of qualified health care professionals, the majority of primary stroke centers have fewer than 300 inpatient beds and the majority of comprehensive stroke centers have more than 300 beds.
[24] AMERICAN HEART ASSOCIATION, *Primary Stroke Center Certification*, https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/PrimaryStrokeCenterCertification/Primary-Stroke-Center-Certification_UCM_439155_SubHomePage.jsp (last visited March 7, 2017).

the American Heart Association/American Stroke Association or equivalent guidelines.[25] These hospitals must also collect and utilize performance data to improve quality of care for stroke patients.[26]

In order for AHCA to designate a hospital program as a primary stroke center, the hospital program must be certified by the Joint Commission as a primary stroke center, or meet the criteria applicable to primary stroke centers as outlined in the Joint Commission Disease-Specific Care Certification Manual, 2nd Edition.[27]

Under the Joint Commission, certified primary stroke centers must meet the standards for Disease-Specific Care Certification:[28]

- Use a standardized method of delivering care;
- Support patient self-management activities;
- Tailor treatment and intervention to individual needs;
- Promote the flow of patient information across settings and providers, while protecting patient rights, security and privacy;
- Analyze and use standardized performance measure data to continually improve treatment plans; and
- Demonstrate their application of and compliance with clinical practice guidelines published by the American Heart Association/American Stroke Association or equivalent evidence-based guidelines[29]

Comprehensive Stroke Centers

A comprehensive stroke center certification recognizes hospitals that meet standards to treat the most complex stroke cases.[30] These hospitals must meet all the criteria of a primary stroke center; they must also have advanced imaging techniques and personnel trained in vascular neurology, neurosurgery and endovascular procedures available 24/7, as well as neuroscience ICU facilities and capabilities and experience and expertise treating patients with large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.

In order for AHCA to designate a hospital program as a compressive stroke center, the hospital program must have received primary stroke center designation and also have personnel with clinical expertise in specified disciplines available,[31] advanced diagnostic capabilities,[32] neurological surgery

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[25] Id.
[26] Id.
[27] Rule 59A-3.2085(15)(a), F.A.C. Currently, in lieu of the Joint Commission, hospitals may choose to use the Healthcare Facilities Accreditation Program or DNV GL (formerly known as Det Norske Veritas) for certification.
[28] The standards are published in the Comprehensive Certification Manual for Disease-Specific Care. They incorporate the "Recommendations for the Establishment of Primary Stroke Centers" developed by the Brain Attack Coalition. The chapters address program management, delivering or facilitating clinical care, supporting self-management, clinical information management, and performance improvement and measurement.
[29] THE JOINT COMMISSION, *Facts about Primary Stroke Center Certification*, https://www.jointcommission.org/facts_about_primary_stroke_center_certification/ (last visited March 2, 2017).
[30] AMERICAN HEART ASSOCIATION, *Comprehensive Stroke Center Certification*, https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/ComprehensiveStrokeCenterCertification/Comprehensive-Stroke-Center-Certification_UCM_455446_SubHomePage.jsp (last visited March 7, 2017).
[31] Rule 59A-3.2085(15)(b), F.A.C. This must include designated comprehensive stroke center medical director; neurologists, neurosurgeons, surgeons with expertise performing carotid endartrectomy, diagnostic neuroradiologists, and physicians with expertise in endovascular neurolnterventional procedures and other pertinent physicians; emergency department physicians and nurses trained in the care of stroke patients; nursing staff in the stroke unit with particular neurologic expertise who are trained in the overall care of stroke patients; nursing staff in intensive care unit with specialized training in care of patients with complex and/or severe neurological/neurosurgical conditions; advanced practice nurses with particular expertise in neurological and/or neurosurgical evaluation and treatment, physicians with specialized expertise in critical care for patients with severe and/or complex neurological/neurosurgical conditions; physicians with specialized expertise in critical care for patients with severe and/or complex neurological/neurosurgical conditions; physicians with expertise in performing and interpreting trans-thoracic echocardiography, transesophageal echocardiography, carotid duplex ultrasound and transcranial Doppler; physicians and therapists with training in rehabilitation, including physical, occupational and speech therapy; and a multidisciplinary team of health care professionals with

and endovascular interventions, [33] and specialized infrastructure,[34] and quality improvement and clinical outcomes measurement.[35] The specialized infrastructure includes extensive requirements that emergency medical services (EMS) link to ensure that EMS uses of a stroke triage assessment tool, that EMS assessment/management at the scene is consistent with evidence-based practice, facilitate inter-facility transfers, and to maintain an on-going communication system with EMS providers regarding availability of services; and that a comprehensive stroke center must:

- Maintain an acute stroke team available 24 hours per day, 7 days per week, and a system for facilitating inter-facility transfers, and a defined access telephone numbers in a system for accepting appropriate transfer;
- Maintain specialized inpatient units including an ICU with medical and nursing personnel who have special training, skills and knowledge in the management of patients with all forms of neurological/neurosurgical conditions that require intensive care; and an acute stroke unit with medical and nursing personnel who have training, skills and knowledge sufficient to care for patients with neurological conditions, particularly acute stroke patients, and who are appropriately trained in neurological assessment and management;
- Provide inpatient post-stroke rehabilitation and ensure continuing arrangements post-discharge for rehabilitation needs and medical management;
- Fulfill the educational needs of its medical and paramedical professionals by offering ongoing professional education for all disciplines; and provide education to the public and inpatients and families on risk factor reduction/management, primary and secondary prevention, the warning signs and symptoms of stroke, and medical management and rehabilitation for stroke patients;
- Provide a career development track to develop neuroscience nursing, particularly in the area of cerebrovascular disease; and
- Have the professional and administrative infrastructure necessary to conduct clinical trials and should have participated in stroke clinical trials within the last year and actively participate in ongoing clinical stroke trials.[36]

Stroke Patient Transportation

Section 395.3041(2), F.S., requires the Department of Health (DOH) to develop a stroke assessment tool. The tool is available on DOH's website and is provided to emergency medical service providers.[37] Each licensed emergency medical services provider must use a stroke-triage assessment tool that is

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expertise or experience in stroke, representing clinical or neuropsychology, nutrition services, pharmacy, including a Pharmacy Doctorate with stroke expertise, case management and social workers. Additionally, medical personnel with neurosurgical expertise must be available in a CSC on a 24 hours per day, 7 days per week basis and in-house within 2 hours, and neurologist(s) with special expertise in the management of stroke patients should be available 24 hours per day, 7 days per week.

[32] Rule 59A-3.2085(15)(b), F.A.C. This includes magnetic resonance imaging and related technologies, catheter angiography, Coaxial Tomography angiography, extracranial ultrasonography, carotid duplex, Transcranial Doppler, transthoracic and trans-esophageal echocardiography, tests of cerebral blood flow and metabolism, and comprehensive hematological and hypercoagulability profile testing.

[33] Rule 59A-3.2085(15)(b), F.A.C. This includes angioplasty and stenting of intracranial and extracranial arterial stenosis, endovascular therapy of acute stroke, endovascular treatment of intracranial aneurysms, endovascular and surgical repair of arteriovenous malformations (AVMs) and arteriovenous fistulae (AVFs), surgical clipping of intracranial aneurysms, intracranial angioplasty for vasospasm, surgical resection of AVMs and AVFs, placement of ventriculostomies and ventriculoperitoneal shunts, evacuation of intracranial hematomas, carotid endarterectomy, and decompressive craniectomy.

[34] Rule 59A-3.2085(15)(b), F.A.C.

[35] Rule 59A-3.2085(15)(b), F.A.C. The purpose of a quality improvement program is analysis of data, correction of errors, systems improvements, and ongoing improvement in patient care and delivery of services. Specific benchmarks, outcomes, and indicators should be defined, monitored, and reviewed on a regular basis for quality assurance purposes. Outcomes for procedures such as carotid endarterectomy, carotid stenting, IVtPA, endovascular/interventional stroke therapy, intracerebral aneurysm coiling, and intracerebral aneurysm clipping should be monitored. A database and/or registry should be established that allows for tracking of parameters such as length of stay, treatments received, discharge destination and status, incidence of complications (such as aspiration pneumonia, urinary tract infection, deep venous thrombosis), and discharge medications and comparing to institutions across the country. Additionally, the comprehensive stroke center must participate in a national and/or state registry (or registries) for acute stroke therapy clinical outcomes, including IVtPA and endovascular/interventional stroke therapy.

[36] Rule 59A-3.2085(15)(b), F.A.C.

[37] S. 395.3041(2), F.S.

substantially similar to DOH's stroke-triage assessment tool.[38] Annually, by June 1, DOH sends the list of primary stroke centers and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in Florida.[39]

Stroke Center Inventory

AHCA must maintain an inventory of hospitals offering stroke services.[40] A listing of hospitals meeting the criteria as either a primary stroke center or comprehensive stroke center, is published on AHCA's website.[41] A list of hospitals with a stroke center designation is also available through the facility locator tool on www.floridahealthfinder.gov.[42]

Currently, there are no data reporting requirements for stroke centers related to quality measures.[43] There are 274 emergency medical service providers, 222 acute care hospitals and 25 medical examiner districts that report patient data to DOH.[44] However, the data is not standardized and much of the data that DOH currently collects comes from voluntary participation in DOH's EMS Tracking and Reporting System (EMSTARS) program[45] and only includes data on response, provider impression, procedures and medication and destination.[46]

The Florida Puerto Rico Stroke Registry

In 2009, the University of Miami Miller School of Medicine created the Florida Puerto Collaboration to Reduce Stroke Disparities (FPCRSD) aims to address stroke disparities among African Americans and Hispanics and to identify the best approaches to eliminate stroke care disparities in these groups.[47] As part of this initiative, it also created a voluntary stroke registry among hospitals in Florida and Puerto Rico currently participating in the American Heart Association's (AHA) quality improvement initiative "Get With The Guidelines Stroke."[48] The Florida Puerto Rico Stroke Registry aims to:

- Leverage the power of data already collected through the AHA's stroke database to identify and address disparities in stroke care;
- Evaluate disparities in stroke care performance metrics by race, ethnicity, and geographic regions;
- Analyze the frequency of disparities at 30-days after a stroke in terms of outcomes (mortality, hospital readmission, stroke recurrence) medication adherence, and lifestyle modifications by race, ethnicity and geographic regions;
- Evaluate the frequency of disparities in longer-term outcomes (mortality, hospital readmission, stroke recurrence) among Medicare patients and the relationship of such outcomes with acute stroke performance metrics; and
- Implement education programs among healthcare stakeholders with a focus on identifying and implementing specific culturally-tailored quality improvement programs to address disparities.[49]

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[38] Id.
[39] S. . 395.3041(1), F.S.
[40] S. 395.3038, F.S.
[41] *Supra*, note 23.
[42] Id.
[43] Id.
[44] Florida Department of Health, Agency Analysis of 2017 House Bill 785, (Feb. 1, 2017) (analysis on file with Health Quality Subcommittee Staff).
[45] The EMSTARS program allows emergency medical providers to capture incident level patient care records for every emergency activation.
[46] *Supra*, note 44.
[47] THE UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE, *Florida-Puerto Rico Collaboration to Reduce Stroke Disparities: About*, http://spirp.med.miami.edu/about (last visited March 7, 2017).
[48] Id.
[49] THE UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE, *Florida Puerto Rico Stroke Registry*, http://spirp.med.miami.edu/program-components/florida-puerto-rico-stroke-registry (last visited March 7, 2017).

Hospitals submit data on measures established by the AHA's "Get With The Guidelines Stroke." These reporting measures include:

- Demographic information for patients;
- Patient arrival mode;
- Time from last known well to triage (ED arrival);
- Time from ED arrival to initial imaging work-up;
- Time from hospital arrival to initiation of specified therapies;
- Types of complications seen with specified therapies;
- Reasons why eligible stroke patients were not treated with specified services;
- Rate of prescription of different types of anti-hypertensive medications, antithrombotic medication, or diabetic medications prescribed at discharge;
- In-hospital mortality and risk-adjusted mortality measures;
- Percent of patient records that are saved as complete;
- Percent of patients where the "Get With The Guidelines" criteria are met; and
- Joint Commission core measures for primary stroke centers.[50]

As of March 2014, there were 64 Florida hospitals, and nine Puerto Rican hospitals participating in the Florida-Puerto Rico Stroke Registry.[51]

Acute Stroke Ready Centers

Many patients with an acute stroke live in areas without ready access to a primary or comprehensive stroke center; more than half the United States population lives more than an hour away from a stroke center.[52] Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke.[53] In such settings, there is a need to distinguish between those that offer enhanced care and expertise for acute stroke versus those with only basic or no organized abilities and expertise.[54]

A recent study by the American Stroke Association proposed a new designation for hospitals that are not primary stroke centers, but can provide timely, evidence-based care to most patients with an acute stroke; these acute stroke-ready hospitals provide initial diagnostic services, stabilization, emergent care and therapies to patients with an acute stroke who are seen in their emergency department, and would then transfer these patients to a primary or comprehensive stroke center.[55]

The Joint Commission, the Healthcare Facilities Accreditation Program, and DNV GL (formerly known as Det Norske Veritas) offer certification as acute stroke ready centers.[56]

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[50] AMERICAN HEART ASSOCIATION/ AMERICAN STROKE ASSOCIATION, *Get With The Guidelines: Stroke Fact Sheet*, available at http://www.heart.org/idc/groups/heart-public/@wcm/@gwtg/documents/downloadable/ucm_310976.pdf (last visited March 7, 2017).
[51] THE UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE, *FL-PR Stroke Registry Participants*, http://spirp.med.miami.edu/registry-participants (last visited March 7, 2017).
[52] Mark J. Alberts, et a., *Formation and Function of Acute Stroke–Ready Hospitals Within a Stroke System of Care Recommendations From the Brain Attack Coalition*, STROKE, Vol. 44, Issue 12 (Nov. 25, 2013), http://stroke.ahajournals.org/content/44/12/3382.full (last visited March 2, 2017).
[53] Id.
[54] Id.
[55] Id.
[56] *Supra*, note 23.

Effect of the Bill

Acute Stroke Ready Centers

CS/HB 785 amends s. 395.3038, F.S. to include a new level of stroke services, acute stroke ready centers. A hospital that meets the certification standards for acute stroke ready centers would receive the acute stroke ready center designation from AHCA in the same manner as primary and comprehensive stroke centers currently do. Currently, there are approximately 60 acute care hospitals that do not have primary or comprehensive stroke center designation and may be eligible for acute stroke ready center designation.[57]

This bill also adds acute stroke ready centers in the list of stroke centers DOH supplies to emergency service providers in the state.

Stroke Center Accreditation

The bill removes language requiring AHCA to base stroke center rules solely on criteria established by the Joint Commission and expands criteria to all nationally recognized accreditation organizations.

Statewide Stroke Registry

This bill creates a statewide stroke registry, established by DOH, and requires all stroke centers to submit data to DOH for the registry. DOH will specify the information to be reported to the registry in rule, which must include:

- Demographic information;
- Stroke severity assessments;
- Diagnostic and examination results;
- Time from symptom onset to hospital arrival;
- In-hospital treatments and events;
- Mortality; and
- Discharge destination.

These reports will be used to evaluate stroke care system effectiveness, monitor patient outcomes, improve or modify the stroke care systems. The bill requires DOH to develop electronic forms for stroke centers to report the required information to the registry; DOH must post these forms on its website.

The bill grants liability protection from damages or any other relief for any entity that provides information required by the registry.

The bill requires DOH to contract with a recognized medical organization and its affiliated institutions in the state of Florida to establish and maintain the registry. Additionally, DOH may adopt rules necessary to implement the registry.

Stroke centers that do not comply with the reporting requirements to the registry will be subject to licensure denial, modification, suspension, or revocation by AHCA. Section 395.003(7)(a), F.S., authorizes AHCA to deny, modify, suspend, and revoke a license for the substantial failure to comply with any requirements of Part I of Chapter 395, F.S., which is where the statute establishing the stroke registry is located.

The bill removes obsolete deadlines for DOH to implement the stroke-triage assessment tool.

The bill provides an effective date of July 1, 2017.

[57] *Supra*, note 23.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.3038, F.S., relating to state-listed stroke centers; notification of hospitals.
Section 2: Creates s. 395.30381, F.S., relating to statewide stroke registry.
Section 3: Amends s. 395.3041, F.S, relating to emergency medical services providers; triage and transportation of stroke victims to a stroke center.
Section 4: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will incur rulemaking costs to develop the electronic forms stroke centers will utilize to submit the required information. Current resources can absorb these costs. The DOH may also incur the cost of contracting with a medical organization to establish and maintain the registry.

   AHCA will incur rulemaking costs related to updating criteria for acute stroke ready centers and comprehensive stroke centers. Current resources can absorb these costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Public hospitals, emergency medical service providers, and medical examiner offices that would be required to submit data to DOH may be required the purchase of new software and incur labor costs to collect, maintain and send required data to DOH.[58] The estimated cost of this is unknown at this time.[59]

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private hospitals, emergency medical service providers, and medical examiner offices that would be required to submit data to DOH may be required to purchase software and incur labor costs to collect, maintain, and send required data to DOH.[60] The estimated cost of this is unknown at this time.[61]

D. FISCAL COMMENTS:

The bill as drafted requires DOH to contract with a medical organization to establish and maintain the registry. It is unknown what this may cost. HB 3769 was heard in the Health Care Appropriations Subcommittee on 3/14/17 and reported favorably. The bill requests $1 million nonrecurring General Revenue for the University of Miami Stroke Registry.

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[58] *Supra*, note 44.
[59] Id.
[60] Id.
[61] Id.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

As drafted the shall clause on lines 78 and 93 would cause a negative fiscal impact on the DOH.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2017, the Health Quality Subcommittee adopted an amendment that:

- Required DOH to contract with a recognized medical organization to establish and maintain the statewide stroke registry.
- Required the contractor to maintain the registry and make available the reports for use in any study to reduce morbidity or mortality or to improve the stroke care system.
- Specified the information that stroke centers must report to the stroke registry.
- Removed the requirement that emergency medical service providers submit data to the registry.
- Required DOH, instead of AHCA to develop the electronic form for stroke centers to use to report to the registry, and requires DOH to make this form available on its website.

The bill was reported favorably as a committee substitute. This analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

A bill to be entitled

An act relating to stroke centers; amending s. 395.3038, F.S.; directing the Agency for Health Care Administration to include hospitals that meet the criteria for acute stroke ready centers on a list of stroke centers; creating s. 395.30381, F.S.; requiring stroke centers to provide certain information to the Department of Health; requiring the department to establish a statewide stroke registry; providing immunity from liability under certain circumstances; requiring the department to develop electronic reporting forms and post such forms on its website; authorizing the department to adopt rules; amending s. 395.3041, F.S.; conforming a provision and deleting obsolete dates; providing an effective date.

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

Section 1. Section 395.3038, Florida Statutes, is amended to read:

395.3038 State-listed ~~primary stroke centers and comprehensive~~ stroke centers; notification of hospitals.—

(1) The agency shall make available on its website and to the department a list of the name and address of each hospital that meets the criteria for an acute stroke ready center, a

primary stroke center, or ~~and the name and address of each hospital that meets the criteria for~~ a comprehensive stroke center. The list of ~~primary and comprehensive~~ stroke centers must include only those hospitals that attest in an affidavit submitted to the agency that the hospital meets the named criteria, or those hospitals that attest in an affidavit submitted to the agency that the hospital is certified as an acute stroke ready center, a primary stroke center, or a comprehensive stroke center by a nationally recognized ~~an~~ accrediting organization.

(2)(a) If a hospital no longer chooses to meet the criteria for an acute stroke ready center, a primary stroke center, or a comprehensive stroke center, the hospital shall notify the agency and the agency shall immediately remove the hospital from the list of stroke centers.

(b)1. This subsection does not apply if the hospital is unable to provide stroke treatment services for a period of time not to exceed 2 months. The hospital shall immediately notify all local emergency medical services providers when the temporary unavailability of stroke treatment services begins and when the services resume.

2. If stroke treatment services are unavailable for more than 2 months, the agency shall remove the hospital from the list of ~~primary or comprehensive~~ stroke centers until the hospital notifies the agency that stroke treatment services have

been resumed.

(3) The agency shall adopt by rule criteria for an acute stroke ready center, a primary stroke center, and a comprehensive stroke center which are substantially similar to the certification standards for the same categories of ~~primary~~ stroke centers of a nationally recognized accrediting organization ~~the Joint Commission~~.

~~(4) The agency shall adopt by rule criteria for a comprehensive stroke center. However, if the Joint Commission establishes criteria for a comprehensive stroke center, agency rules shall be substantially similar.~~

(4)~~(5)~~ This act is not a medical practice guideline and may not be used to restrict the authority of a hospital to provide services for which it is licensed under chapter 395. The Legislature intends that all patients be treated individually based on each patient's needs and circumstances.

Section 2. Section 395.30381, Florida Statutes, is created to read:

395.30381 Statewide stroke registry.—

(1) Each acute ready stroke center, primary stroke center, and comprehensive stroke center shall report to the department information specified in department rule, including, but not limited to, demographic information, stroke severity assessments, diagnostic and examination results, time from symptom onset to hospital arrival, in-hospital treatments and

events, mortality, and discharge destination for each stroke patient treated by a stroke center.

(2) The department shall contract with a recognized medical organization in this state and its affiliated institutions to establish and maintain a statewide stroke registry. The medical organization shall maintain and make available the reports required under this section for use in the course of any study for the purpose of reducing morbidity or mortality or improving the stroke care system. Such reports shall be used to evaluate stroke care system effectiveness, monitor patient outcomes, and improve or modify the stroke care system.

(3) No liability of any kind or character for damages or other relief shall arise or be enforced against any acute ready stroke center, primary stroke center, or comprehensive stroke center by reason of having provided such information to the department.

(4) The department shall develop electronic forms for each acute ready stroke center, primary stroke center, and comprehensive stroke center to report required information to the registry. The department must post these forms on its website.

(5) The department may adopt rules to administer this section.

Section 3. Subsections (1), (2), and (4) of section

395.3041, Florida Statutes, are amended to read:

395.3041 Emergency medical services providers; triage and transportation of stroke victims to a stroke center.—

(1) By June 1 of each year, the department shall send the list of acute stroke ready centers, primary stroke centers, and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in this state.

(2) The department shall develop a sample stroke-triage assessment tool. The department must post this sample assessment tool on its website and provide a copy of the assessment tool to each licensed emergency medical services provider ~~no later than June 1, 2005~~. Each licensed emergency medical services provider must use a stroke-triage assessment tool that is substantially similar to the sample stroke-triage assessment tool provided by the department.

(4) Each emergency medical services provider licensed under chapter 401 must comply with all sections of this act ~~by July 1, 2005~~.

Section 4. This act shall take effect July 1, 2017.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Magar offered the following:

Amendment (with title amendment)

Remove lines 78-87 and insert:

(2) The department may establish a statewide stroke registry to ensure that patient care quality assurance proceedings, records, and reports required to be submitted under subsection (1) are maintained and available for use to improve or modify the stroke care system, ensure compliance with standards, and monitor stroke patient outcomes. Subject to a specific appropriation for this purpose, the department shall contract with a private entity to establish and maintain a registry.

Remove line 93 and insert:

(4) The department may develop electronic forms for each

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

Remove lines 8-9 and insert:

Department of Health; permitting the department to establish a statewide stroke registry; requiring the department to contract with a private entity to establish and maintain a registry subject to an appropriation; providing

Remove line 11 and insert:

permitting the department to develop electronic

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Postdoctoral Research Program at Scripps Florida
2. Date of Submission: 01/17/2017
3. House Member Sponsor: MaryLynn Magar
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? Yes
   If answer to 4a is "NO" skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded? 2016-17
c. Were the funds provided in the most recent fiscal year subsequently vetoed? Yes
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:		1,000,000			1,400,000	1,400,000

5. Are funds for this issue requested in a state agency's Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Health

6. Requester:
   a. Name: Richard King, PhD.
   b. Organization: Scripps Research Institute
   c. Email: rking@scripps.edu
   d. Phone #: (000)000-0000

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Richard King, PhD.
   b. Organization: Scripps Research Institute
   c. Email: rking@scripps.edu
   d. Phone #: (000)000-0000

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Jerry McDaniel
   b. Firm: Southern Strategy Group
   c. Email: mcdaniel@sostrategy.com
   d. Phone #: (850)566-6068

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: The Scripps Research Institute Florida
   b. County (County where funds are to be expended): Palm Beach
   c. Service Area (Counties being served by the service(s) provided with funding): Statewide

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

The State of Florida educates and graduates about 2000 STEM doctoral students a year. In Florida, it is challenging for these doctoral graduates who wish to remain in Florida to find suitable postdoctoral training positions, as the number of qualified institutions are limited. Scripps Florida proposes to use these funds to recruit and pay top quality Florida graduate students to be postdocs in the Scripps Florida Labs.The request would fund 20 postdocs in fiscal 2017/18 for a min of 3 years.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter "0" if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☐b. Other Salary and Benefits		
☐c. Expense/Equipment/Travel/Supplies/Other		
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☑e. Salaries and Benefits	salaries	1,400,000
☐f. Expenses/Equipment/Travel/Supplies/Other		
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		1,400,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if "h. Fixed Capital Outlay" was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Information being compiled

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

No

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

- ☑ Elderly persons
- ☐ Persons with poor mental health
- ☑ Persons with poor physical health
- ☐ Jobless persons
- ☐ Economically disadvantaged persons
- ☐ At-risk youth
- ☐ Homeless
- ☑ Developmentally disabled
- ☑ Physically disabled
- ☐ Drug users (in health services)
- ☐ Preschool students
- ☐ Grade school students
- ☐ High school students
- ☑ University/college students

☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☐Other (Please describe)

17b. How many in the target population are expected to be served?

○< 25
○25-50
○51-100
○101-200
○201-400
○401-800
⊙>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☐Improve physical health		
☐Improve mental health		
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		
☑Improve quality of education	increased # of post doctorate research students that stay in Florida versus leave the state	progress toward the national average for proportion of workforce that has a post graduate STEM background (.15%=FL.; .24% = national average.)
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		

☐Improve transportation conditions		
☐Increase or improve economic activity		
☐Increase tourism		
☑Create specific immediate job opportunities	increased # of post doctorate research students that stay in Florida versus leave the state	progress toward the national average for proportion of workforce that has a post graduate STEM background (.15%=FL.; .24% = national average.)
☐Enhance specific individual's economic self sufficiency		
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter "0" if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations	1,400,000	100.0%	N/A

Project Request:			
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	1,400,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
Yes

20a. How much state funding would be requested after 2017-18 over the next 5 years?
- O<1M
- ⊙1-3M
- O>3-10M
- O>10M

20b. How many additional years of state support do you expect to need for this project?
- O1 year
- ⊙2 years
- O3 years
- O4 years
- O>= 5 years

20c. What is the total project cost for all years including all federal, local, state, and any other funds? Select the single answer which best describes the total project cost. If funds requested are for ongoing services or for recurring activities, select "ongoing activity".
- Oongoing activity – no total cost
- O<1M
- O1-2M
- O>2-3M
- ⊙>3-10M

O>10M

A bill to be entitled

An act relating to the Appropriations Project titled Postdoctoral Research Program at Scripps Florida; providing an appropriation; providing an effective date.

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

Section 1. Postdoctoral Research Program at Scripps Florida is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 47, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $1,400,000 from the General Revenue Fund is appropriated to the Department of Health to fund the Postdoctoral Research Program at Scripps Florida as described in Appropriations Project Request 47. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Love and Hope in Action-Shelter Kitchen Renovation
2. Date of Submission: 01/27/2017
3. House Member Sponsor: MaryLynn Magar
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					218,000	218,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Children and Families

6. Requester:
   a. Name: Brenda Dickerson
   b. Organization: Love andHope in Action, Inc.
   c. Email: brenda@lahia.org
   d. Phone #: (772)781-7002

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Mike Stetson
   b. Organization: Love and Hope in Action, Inc LAHIA
   c. Email: jmstet@gmail.com
   d. Phone #: (772)708-5060

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: None
   b. Firm: None
   c. Email:
   d. Phone #:

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Love and Hope in Action, Inc. (LAHIA)
   b. County (County where funds are to be expended): Martin
   c. Service Area (Counties being served by the service(s) provided with funding): Martin

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

funds will be used to renovate and harden the LAHIA facility in order to better serve the homeless and indigent population in Martin County.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☐b. Other Salary and Benefits		
☐c. Expense/Equipment/Travel/Supplies/Other		
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☐e. Salaries and Benefits		
☐f. Expenses/Equipment/Travel/Supplies/Other		
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☑h. Construction/Renovation/Land/Planning Engineering	construction/planning	218,000
TOTAL		218,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

○For Profit
⊙Non Profit 501(c) (3)
○Non Profit 501(c) (4)
○Local Government (e.g., police, fire or local government buildings, local roads, etc.)
○State agency owned facility (For example: college or university facility, buildings for public schools, roads in the state transportation system, etc.)
○Other (Please describe)

14. Is the project request an information technology project?
No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?
Yes

15a. Please Describe:
House of Hope, New Horizons of the Treasure Coast, VIM Vlinic, MC Sheriff's Dept., Martin Health Systems, several churches in MC.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?
Yes

16a. Please Describe:
Feeding America Organization

17. Will the requested funds be used directly for services to citizens?
Yes

17a. Describe the target population to be served. Select all that apply to the target population:
☑Elderly persons
☑Persons with poor mental health
☑Persons with poor physical health
☑Jobless persons
☑Economically disadvantaged persons
☑At-risk youth
☑Homeless
☑Developmentally disabled

☑Physically disabled
☐Drug users (in health services)
☑Preschool students
☑Grade school students
☑High school students
☑University/college students
☑Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☑Victims of crime
☐Other (Please describe)

17b. How many in the target population are expected to be served?
O< 25
O25-50
O51-100
O101-200
O201-400
⊙401-800
O>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Logging and tracking # of meal served to homeless and indigent in Martin County, as well as providing access to medical resources.	providing nutritious meals and access to medical care including vision and dental services
☑Improve mental health	logging and tracking # of referrals to mental health services and individuals medication management.	individuals receiving mental health counseling and medication mgmt.
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		

☐Improve quality of education		
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☐Increase or improve economic activity		
☐Increase tourism		
☐Create specific immediate job opportunities		
☑Enhance specific individual?s economic self sufficiency	decreasing the amount of individuals dependent on public or charitable assistance.	assisting individuals in activities to becoming self sufficient.
☐Reduce recidivism		
☑Reduce substance abuse	tracking # of individuals referred to substance abuse and alcohol treatment facilities.	Individuals will become less dependent on substance abuse and alcohol.
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	218,000	100.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	61,000	0.0%	Yes
5. Other:	0	0.0%	No
TOTAL	279,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled Love and Hope in Action-Shelter Kitchen Renovation; providing an appropriation; providing an effective date.

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

Section 1. Love and Hope in Action-Shelter Kitchen Renovation is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 180, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $218,000 from the General Revenue Fund is appropriated to the Department of Children and Families to fund the Love and Hope in Action-Shelter Kitchen Renovation as described in Appropriations Project Request 180. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: State Veterans' Nursing Home Planning-Marion County
2. Date of Submission: 02/02/2017
3. House Member Sponsor: Stan McClain
   Members Copied: Don Hahnfeldt, Charlie Stone, Clovis Watson

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					500,000	500,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Veterans Affairs

6. Requester:
   a. Name: Carl Zalak
   b. Organization: Marion County Board of County Commissioners
   c. Email: Carl.Zalak@marioncountyfl.org
   d. Phone #: (352)438-2323

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Jeannie Rickman
   b. Organization: Marion County Board of County Commissioners
   c. Email: Jeannie.Rickman@marioncountyfl.org
   d. Phone #: (352)438-2307

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: John Wayne
   b. Firm: Peebles & Smith
   c. Email: john@peebles-smith.com
   d. Phone #: (850)681-7383

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Marion County Board of County Commissioners
   b. County (County where funds are to be expended): Marion
   c. Service Area (Counties being served by the service(s) provided with funding): Statewide

10. What type of organization is the entity that will receive the funds? (Select one)
   - ○ For Profit
   - ○ Non Profit 501(c) (3)
   - ○ Non Profit 501(c) (4)
   - ⊙ Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

To provide financial support and needs for a State Veteran's Nursing Home in Marion County, Florida. The community will serve a total Veteran population of 649,460 Veterans within a 75 mile radius.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☐b. Other Salary and Benefits		
☐c. Expense/Equipment/Travel/Supplies/Other		
☑d. Consultants/Contracted Services/Study	For consultants, studies and contracted services including to ensure the site is appropriate for the site, all State and U.S. Department of Veterans Affairs (VA) environmental concerns are met, and analyzing soil samples.	500,000
Operational Costs:		
☐e. Salaries and Benefits		
☐f. Expenses/Equipment/Travel/Supplies/Other		
☐g. Consultants/Contracted Services/Study		

Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		500,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Governor Rick Scott proposed funding in 2015 for three new state Veterans Nursing homes. In addition, Marion County has letters of support from the Florida Department of Veterans' Affairs, Senators, State Representatives, Veterans organizations, local educational facilities, other members of the community, 2014 FDVA Nursing Home site visit with thousands of community supporters attending.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

Yes

16a. Please Describe:

2014, Florida Department of Veterans' Affairs briefed Governor Rick Scott on the results of an independent study recommending the construction of additional Veterans' homes in Florida. The study showed Marion County was one of ten Florida counties with the greatest need for a Veterans' home.

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☑Elderly persons

☑Persons with poor mental health

☑Persons with poor physical health
☐Jobless persons
☐Economically disadvantaged persons
☐At-risk youth
☐Homeless
☑Developmentally disabled
☑Physically disabled
☐Drug users (in health services)
☐Preschool students
☐Grade school students
☐High school students
☐University/college students
☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☐Other (Please describe)

17b. How many in the target population are expected to be served?
○< 25
○25-50
○51-100
◉101-200
○201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Specific measures of improved physical health would be determined by the medical staff according to each individual patient's needs.	Methods for measuring the level of benefit or outcome would be determined by the medical staff according to each individual patient's needs.

☑Improve mental health	Specific measures of improved mental health would be determined by the medical staff according to each individual patient's needs.	Methods for measuring the level of benefit or outcome would be determined by the medical staff according to each individual patient's needs.
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		
☐Improve quality of education		
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☑Increase or improve economic activity	Lower unemployment rates. Increased local spending and income.	Comparing employment rates before and after the construction of the nursing home. Comparing local businesses income before and after the construction of the nursing home.
☐Increase tourism		
☑Create specific immediate job opportunities	Unemployment and underemployment rates should be lowered.	Comparing employment rates before and after the construction of the nursing home.
☑Enhance specific individual?s economic self sufficiency	Average income of both individuals and families within Marion County.	Comparing the average income before and after the construction of the nursing home.
☐Reduce recidivism		

☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	500,000	100.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	500,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled State Veterans' Nursing Home Planning-Marion County; providing an appropriation; providing an effective date.

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

Section 1. State Veterans' Nursing Home Planning-Marion County is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 434, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $500,000 from the General Revenue Fund is appropriated to the Department of Veterans Affairs to fund the State Veterans' Nursing Home Planning-Marion County as described in Appropriations Project Request 434. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Veterans' Home Program-City of Pembroke Pines
2. Date of Submission: 01/31/2017
3. House Member Sponsor: Shevrin Jones
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					120,000	120,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Veterans Affairs

6. Requester:
   a. Name: Aner Gonzalez
   b. Organization: Assistant City Manager, City of Pembroke Pines
   c. Email: agonzalez@ppines.com
   d. Phone #: (954)450-1034

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Jonathan Bonilla
   b. Organization: Controller, City of Pembroke Pines
   c. Email: jbonilla@ppines.com
   d. Phone #: (954)518-9036

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Candice Ericks
   b. Firm: Ericks Consultants
   c. Email: candice@ericksconsultants.com
   d. Phone #: (954)648-1204

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: The City of Pembroke Pines
   b. County (County where funds are to be expended): Broward
   c. Service Area (Counties being served by the service(s) provided with funding): Broward

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - O Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - ⊙ Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

In support of United States Veterans and their families, the City of Pembroke Pines has successfully renovated five 5 bedroom homes located on the Howard C. Forman Health Campus. Being acutely aware of the PTS impact on Veterans, the funding request would assist with the opportunity to experience Post Traumatic Growth (PTG). Services such as counselling and other jobs, emotional and life coaching services and financial assistance as needed, would be provided using the appropriations requested.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☐b. Other Salary and Benefits		
☐c. Expense/Equipment/Travel/Supplies/Other		
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☐e. Salaries and Benefits		
☑f. Expenses/Equipment/Travel/Supplies/Other	Financial Assistance for Veterans as needed	36,000
☑g. Consultants/Contracted Services/Study	Professional services for counselling, job training, life coaching for veterans and their families.	84,000
Fixed Capital Construction/Major Renovation:		

☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		120,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

No

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

No

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☐Elderly persons
☐Persons with poor mental health
☐Persons with poor physical health
☐Jobless persons
☐Economically disadvantaged persons
☐At-risk youth
☐Homeless
☐Developmentally disabled
☐Physically disabled
☐Drug users (in health services)
☐Preschool students
☐Grade school students
☐High school students
☐University/college students

☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☑Other (Please describe): Returning American Veterans

17b. How many in the target population are expected to be served?
○< 25
○25-50
⊙51-100
○101-200
○201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☐Improve physical health		
☐Improve mental health		
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		
☐Improve quality of education		
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☐Increase or improve economic activity		

☐Increase tourism		
☐Create specific immediate job opportunities		
☑Enhance specific individual?s economic self sufficiency	These homes would provide an opportunity for returning veterans and their families to be together and begin the process to mainstream back into the community.	Tenant occupancy rate, length of tenant stay, qualification rate, subsidy report, counselling participation rate.
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	120,000	80.0%	N/A
2. Federal:	0	0.0%	No

3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	30,000	20.0%	Yes
5. Other:	0	0.0%	No
TOTAL	150,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled Veterans' Home Program-City of Pembroke Pines; providing an appropriation; providing an effective date.

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

Section 1. Veterans' Home Program-City of Pembroke Pines is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 274, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $120,000 from the General Revenue Fund is appropriated to the Department of Veterans Affairs to fund the Veterans' Home Program-City of Pembroke Pines as described in Appropriations Project Request 274. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: The Arc Jacksonville - Transition to Community Employment
2. Date of Submission: 02/02/2017
3. House Member Sponsor: W. Cummings
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					300,000	300,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Agency for Persons with Disabilities

6. Requester:
   a. Name: Jim Whittaker
   b. Organization: The Arc Jacksonville
   c. Email: jwhittaker@arcjacksonville.org
   d. Phone #: (904)355-0155

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Jim Whittaker
   b. Organization: The Arc Jacksonville
   c. Email: jwhittaker@arcjacksonville.org
   d. Phone #: (904)355-0155

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: None
   b. Firm: None
   c. Email:
   d. Phone #:

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: The Arc Jacksonville, Inc.
   b. County (County where funds are to be expended): Duval
   c. Service Area (Counties being served by the service(s) provided with funding): Clay, Duval, Saint Johns

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

Demonstration Project to develop best practices to address new federal mandates to transition individuals with developmental disabilities and mental illness from facility based program to community employment and more inclusive settings.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☑b. Other Salary and Benefits	Project Administrator %	40,000
☑c. Expense/Equipment/Travel/Supplies/Other	Best Practices - Site Travel	10,000
☑d. Consultants/Contracted Services/Study	Best Practices - Research/Consultant	35,000
Operational Costs:		
☑e. Salaries and Benefits	(4) Transition Coaches	200,000
☑f. Expenses/Equipment/Travel/Supplies/Other	Community Transport/Supplies	15,000
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		300,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Endorsed by the Jacksonville Chamber of Commerce and City of Jacksonville

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

No

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

- ☐Elderly persons
- ☑Persons with poor mental health
- ☐Persons with poor physical health
- ☑Jobless persons
- ☑Economically disadvantaged persons
- ☐At-risk youth
- ☐Homeless
- ☑Developmentally disabled
- ☑Physically disabled
- ☐Drug users (in health services)
- ☐Preschool students
- ☐Grade school students
- ☐High school students
- ☐University/college students

☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☐Other (Please describe)

17b. How many in the target population are expected to be served?
○< 25
○25-50
⊙51-100
○101-200
○201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Physical disabilities (part of the IDD spectrum) are a group of conditions due to an impairment in physical, learning, language, or behavior areas. The Demonstration project will include investigating various techniques to improve employment and support opportunities especially related to the social and access perspective for individuals with physical disabilities.	Pre and post-demonstration questionaires and feedback based on the following: Learning and applying knowledge, self-care for general tasks and demands, communication, mobility and changes to participants perspective of community, social, and civic life.
☑Improve mental health	The Demonstration project will develop and test the effectiveness of various techniques to improve mental health. Emotional skills will help lead to a greater sense of well-being, accomplishment, and pride and	Pre-launch surveys, feedback from focus groups, program evaluations and post-implementation satisfaction ratings from program participants, support staff, etc. will be used to

	confidence. Cognitive skills are the underlying skills that must be in place for an individual to think, read, understand, remember, plan and organize. When mental health is managed well, a person can lead a more productive life and have longer periods of stability.	measure program effectiveness.
☑Enrich cultural experience	Rich cultural experiences enhance the quality of life for people of all abilities. Individuals with I/DD and mental health issues continue to face prejudice and discrimination that limit their social inclusion, thereby limiting cultural diversity and understanding. The demonstration project will devise programs & activities that help develop friendships, expand knowledge of others, develop and maintain relationships and help to create a sense of belonging unlike sequestration.	Subjective assessments will include anecdotal information from pre-launch surveys and post-implementation satisfaction ratings from program participants, support staff, etc. Objective measurements will include the number of social events attended, community events, the number of new friendships formed and participation in cultural activities.
☐Improve agricultural production/promotion/education		
☑Improve quality of education	A finding in the Journal of Vocational Rehabilitation (vol. 22 - 2005) noted that coordinated programs to educate faculty, peers, and employers need to be implemented to decrease discriminatory attitudes and further increase success in post-secondary education and subsequent employment for persons with I/DD &	The Arc Jacksonville coordinates with other agencies such as Vocational Rehabilitation, Florida Agency for Persons with Disabilities, the University of North Florida, etc. and will include these organizations in focus groups to provide feedback, feasibility studies, and evaluations where applicable.

	mental health issues.	
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☑Increase or improve economic activity	The disability community represents $175 billion in discretionary funds (www.ADA.gov) which is further augmented by family members and social-minded customers. Education and outreach to businesses who hire persons with disabilities will help attract this customer base and increase economic activities.	Objective measurement includes: a) Reduction in number of persons in Adult Day Training earning sub-minimum wage b) Number of job partnerships with local employers c) Comparison in number of jobs pre & post project.
☐Increase tourism		
☐Create specific immediate job opportunities		
☑Enhance specific individual?s economic self sufficiency	In comparison with the general population, individuals with developmental disabilities experience lower rates of educational achievement, employment, and annual earnings and are more likely to live in poverty. Most live on $733 per month. The project would move many individuals from sequestered workshops and boost opportunities for individuals with I/DD to compete for jobs based on individual career goals, desires, and skills (obtained	Objective measurements would include: a) Number of individuals successfully completing training programs b) Number of persons procuring community-based jobs c) Measurable increase in salaries per capita for participants in the targeted program.

	through training programs).	
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	300,000	100.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	300,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
Yes

20a. How much state funding would be requested after 2017-18 over the next 5 years?
⊙<1M
○1-3M
○>3-10M
○>10M

20b. How many additional years of state support do you expect to need for this project?
○1 year
⊙2 years
○3 years
○4 years
○>= 5 years

20c. What is the total project cost for all years including all federal, local, state, and any other funds? Select the single answer which best describes the total project cost. If funds requested are for ongoing services or for recurring activities, select ?ongoing activity?.
○ongoing activity ? no total cost
⊙<1M
○1-2M
○>2-3M
○>3-10M
○>10M

A bill to be entitled

An act relating to the Appropriations Project titled The Arc Jacksonville - Transition to Community Employment; providing an appropriation; providing an effective date.

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

Section 1. The Arc Jacksonville - Transition to Community Employment is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 432, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $300,000 from the General Revenue Fund is appropriated to the Agency for Persons with Disabilities to fund the The Arc Jacksonville - Transition to Community Employment as described in Appropriations Project Request 432. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Healthcare Network of Southwest Florida?s Integrated Behavioral Health Services Program
2. Date of Submission: 01/31/2017
3. House Member Sponsor: Byron Donalds
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					2,000,000	2,000,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Children and Families

6. Requester:
   a. Name: Mike Ellis
   b. Organization: Collier Health Services, Inc. d/b/a Healthcare Network of Southwest Florida
   c. Email: mellis@healthcareswfl.org
   d. Phone #: (239)225-5436

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Mike Ellis
   b. Organization: Collier Health Services, Inc. d/b/a Healthcare Network of Southwest Florida
   c. Email: mellis@healthcareswfl.org
   d. Phone #: (239)225-5436

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Keith Arnold
   b. Firm: Buchanan Ingersoll Rooney
   c. Email: keith.arnold@bipc.com
   d. Phone #: (239)985-4837

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Collier HealthServices, Inc. d/b/a Healthcare Network of Sou
   b. County (County where funds are to be expended): Collier
   c. Service Area (Counties being served by the service(s) provided with funding): Collier, Glades, Hendry, Lee

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

To provide behavioral health and care team based services to the Southwest Florida community. This is a one time request, but the service will continue, sustained through over avenues. There is no plan to make this a recurring request in the future.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☑b. Other Salary and Benefits	Director / Administrator salary	500,000
☑c. Expense/Equipment/Travel/Supplies/Other	Misc. overhead of overseeing the program. No major equipment, supply or travel expenses are expected to be paid using state funds. This would primarily be for trainings, this would not exceed $2,500.	500,000
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☑e. Salaries and Benefits	Psycologist / Care Team / Provider Staff salaries	500,000
☑f. Expenses/Equipment/Travel/Supplies/Other	Misc. overhead of overseeing the program. No major equipment, supply or travel expenses are expected to be paid using state funds. This would	500,000

	primarily be for trainings, this would not exceed $2,500.	
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		2,000,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

several local and national organizations that support the integration of behavioral health and supplementation of current behavioral health resources available in the community.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

Yes

16a. Please Describe:

The Collier County Health Depardment 2016 needs assessment states that the community has been verbal about the need for mental health care services.

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☑Elderly persons
☑Persons with poor mental health
☑Persons with poor physical health
☑Jobless persons
☑Economically disadvantaged persons
☑At-risk youth
☑Homeless
☑Developmentally disabled
☑Physically disabled
☑Drug users (in health services)
☑Preschool students
☑Grade school students
☑High school students
☑University/college students
☑Currently or formerly incarcerated persons
☑Drug offenders (in criminal Justice)
☑Victims of crime
☐Other (Please describe)

17b. How many in the target population are expected to be served?

○< 25
○25-50
○51-100
○101-200
○201-400
○401-800
⊙>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Number of behavioral health screenings	Entry into treatment

☑Improve mental health	Number of behavioral health screenings	Entry into treatment
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		
☐Improve quality of education		
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☐Increase or improve economic activity		
☐Increase tourism		
☐Create specific immediate job opportunities		
☐Enhance specific individual?s economic self sufficiency		
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		

☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	2,000,000	37.7%	N/A
2. Federal:	1,500,000	28.3%	Yes
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	900,000	17.0%	Yes
5. Other:	900,000	17.0%	Yes
TOTAL	5,300,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled Healthcare Network of Southwest Florida's Integrated Behavioral Health Services Program; providing an appropriation; providing an effective date.

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

Section 1. Healthcare Network of Southwest Florida's Integrated Behavioral Health Services Program is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 244, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $2,000,000 from the General Revenue Fund is appropriated to the Department of Children and Families to fund the Healthcare Network of Southwest Florida's Integrated Behavioral Health Services Program as described in Appropriations Project Request 244. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Charlotte Behavioral Health Care Community Action Team (CAT) - Charlotte County
2. Date of Submission: 02/01/2017
3. House Member Sponsor: Michael Grant
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					750,000	750,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Children and Families

6. Requester:
   a. Name: Victoria Scanlon
   b. Organization: Charlotte Behavioral Health Center
   c. Email: vscanlon@cbhcfl.org
   d. Phone #: (941)628-4447

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Victoria Scanlon
   b. Organization: Charlotte Behavioral Health Center
   c. Email: vscanlon@cbhcfl.org
   d. Phone #: (941)628-4447

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Ken Pruitt
   b. Firm: P5 Group
   c. Email: ken@TheP5Group.com
   d. Phone #: (772)485-0693

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Charlotte Behavioral Health Care
   b. County (County where funds are to be expended): Charlotte
   c. Service Area (Counties being served by the service(s) provided with funding): Charlotte

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

For youth with mental health and/or substance abuse disorders, strengthen the family system, improve school outcomes, decrease out of home placements, decrease hospitalizations, and reduce involvement with law enforcement and the juvenile justice system.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☑b. Other Salary and Benefits	Administration and Support Staff Time (Including IT, Maintenance, Utilization/Quality Management, Administration, Finance, Human Resources, Medical Records, etc.)	61,829
☑c. Expense/Equipment/Travel/Supplies/Other	Building Occupancy, Insurance, Supplies, Printing, Marketing, Advertising, Miscellaneous	13,171
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☑e. Salaries and Benefits	8.75 FTE CAT Team as described in DCF CAT Evaluation Report (Psychiatrist/ARNP, RN/LPN, Clinicians, etc.)	504,277
☑f. Expenses/Equipment/Travel/Supplies/Other	Building Occupancy, Travel,	170,723

	Equipment, Medical and Pharmacy, Insurance, Operating Supplies, Professional Services, Transportation, Incidentals, Miscellaneous Expense.	
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		750,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Charlotte County Board of Commissioners 2017/2018 legislative priority. Also, letters of support provided by Chairman of Charlotte County Board of Commissioners, Charlotte County Sheriff and Charlotte County School Superintendent. CAT will be discussed at Charlotte county delegation hearing on 1/19/17.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

No

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☐Elderly persons
☑Persons with poor mental health
☑Persons with poor physical health
☐Jobless persons
☑Economically disadvantaged persons
☑At-risk youth
☐Homeless
☐Developmentally disabled
☐Physically disabled
☑Drug users (in health services)
☐Preschool students
☑Grade school students
☑High school students
☐University/college students
☑Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☑Victims of crime
☑Other (Please describe): individuals at risk of juvenile justice involvement; individuals at risk for out-of-home placement

17b. How many in the target population are expected to be served?

○< 25
○25-50
◉51-100
○101-200
○201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☐Improve physical health		

☑Improve mental health	90% youth diverted from psychiatric residential placement 80% youth will improve their level of functioning	DCF State of Florida outcomes data collection
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		
☑Improve quality of education	Youth will attend 80% of school days.	DCF State of Florida outcomes data collection
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☐Increase or improve economic activity		
☐Increase tourism		
☐Create specific immediate job opportunities		
☐Enhance specific individual?s economic self sufficiency		
☑Reduce recidivism	Youth will spend 90% of days living in a community setting (vs psychiatric or DJJ)	DCF State of Florida outcomes data collection
☐Reduce substance abuse		
☑Divert from Criminal/Juvenile justice system	90% of at risk youth will not have juvenile justice Involvement	DCF State of Florida outcomes data collection
☐Improve wastewater management		
☐Improve stormwater management		

☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	750,000	100.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	750,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
Yes

20a. How much state funding would be requested after 2017-18 over the next 5 years?
- O<1M
- ⊙1-3M
- O>3-10M
- O>10M

20b. How many additional years of state support do you expect to need for this project?

○1 year
○2 years
○3 years
○4 years
⊙>= 5 years

20c. What is the total project cost for all years including all federal, local, state, and any other funds? Select the single answer which best describes the total project cost. If funds requested are for ongoing services or for recurring activities, select ?ongoing activity?.

⊙ongoing activity ? no total cost
○<1M
○1-2M
○>2-3M
○>3-10M
○>10M

A bill to be entitled

An act relating to the Appropriations Project titled Charlotte Behavioral Health Care Community Action Team (CAT) - Charlotte County; providing an appropriation; providing an effective date.

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

Section 1. Charlotte Behavioral Health Care Community Action Team (CAT) - Charlotte County is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 321, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $750,000 from the General Revenue Fund is appropriated to the Department of Children and Families to fund the Charlotte Behavioral Health Care Community Action Team (CAT) - Charlotte County as described in Appropriations Project Request 321. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Manatee County Opioid Addiction Recovery Peer Pilot Program
2. Date of Submission: 02/06/2017
3. House Member Sponsor: Joe Gruters
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					500,000	500,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Children and Families

6. Requester:
   a. Name: Nicholas Azzara
   b. Organization: Manatee County Government
   c. Email: nicholas.azzara@mymanatee.org
   d. Phone #: (941)745-3771

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Joshua Barnett
   b. Organization: Manatee County Government
   c. Email: joshua.barnett@mymanatee.org
   d. Phone #: (941)749-3030

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Cari Roth
   b. Firm: Dead Mead Attorneys at Law
   c. Email: croth@deanmead.com
   d. Phone #: (850)999-4100

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Manatee Co Gov; Neighborhood Services/Com Serv. Dept
   b. County (County where funds are to be expended): Manatee
   c. Service Area (Counties being served by the service(s) provided with funding): Manatee

10. What type of organization is the entity that will receive the funds? (Select one)
   O For Profit
   O Non Profit 501(c) (3)
   O Non Profit 501(c) (4)
   O Local Government

○ University or College
⊙ Other (Please describe) Will be competitively procured, unknown at this time

11. What is the specific purpose or goal that will be achieved by the funds being requested?

To implement the evidence-based practice of community-based Peer Coaching utilizing a professional workforce of individuals who have achieved recovery from a substance abuse disorder. Peer Coaches will use their recovery experience to mitigate further adverse outcomes while simultaneously enhancing positive treatment outcomes associated with opioid addiction/dependence.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☑a. Executive Director/Project Head Salary and Benefits	1 FTE Project Head Lead Peer, 0.1 FTE of Executive Organizational Leadership and 0.5 FTE Clinical Lead from the procured agency(ies).	101,920
☐b. Other Salary and Benefits		
☑c. Expense/Equipment/Travel/Supplies/Other	Travel Mileage Reimbursement Documentation Equipment will be an expense related to this contract due to the Community-based outreach methodology of this program type.	5,000
☑d. Consultants/Contracted Services/Study	Evaluation 1.5% of Budget	7,500
Operational Costs:		
☑e. Salaries and Benefits	Peer Coaches will be paid a commensurate rate related to their certification status (CADC, CCDP, CRPS, or the like) and professional	365,580

	work experience. Hourly rates based upon FTE status of each Peer Coach staff.	
☑f. Expenses/Equipment/Travel/Supplies/Other	Peer Coaches will be provided necessary equipment and travel reimbursement for community-based outreach services.	20,000
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		500,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Manatee Board of County Commissioners 01/31/2017 Work Session; Drug Free Manatee's Addiction Crisis Task Force: "Peer Coaches were #1 most suggested necessary resource for opioid-addictions intervention".

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

Yes

16a. Please Describe:

The Drug Free Manatee 'Addiction Crisis Task Force,' a membership made up of Law Enforcement, Government, Treatment Providers, Research Professionals, Educators, and Fellowship had consensus for a Peer Coach Recovery Intervention program.

17. Will the requested funds be used directly for services to citizens?
Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☐Elderly persons
☑Persons with poor mental health
☑Persons with poor physical health
☐Jobless persons
☑Economically disadvantaged persons
☐At-risk youth
☐Homeless
☐Developmentally disabled
☐Physically disabled
☑Drug users (in health services)
☐Preschool students
☐Grade school students
☐High school students
☐University/college students
☑Currently or formerly incarcerated persons
☑Drug offenders (in criminal Justice)
☐Victims of crime
☑Other (Please describe): Opioid abusers & misusers who reside in Manatee Co. with a primary focus on emergency dept. utilizer

17b. How many in the target population are expected to be served?

○< 25
○25-50
○51-100
○101-200
◉201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Of those enrolled in Peer Coach program, reduced utilization of emergency departments related to opioid overdose	Aggregate reduction of emergency department utilization of enrolled opioid abusers
☑Improve mental health	Increased time in community between detox or drug-seeking behavior	Tracking individual and aggregate periods of time not in treatment due to Peer Coaching enrollment
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		
☑Improve quality of education	Community Education provided by Peer Coaches on impacts of opioid prescription abuse, misuse and illicit heroin drug use	Intermittent assessment of community education events and comprehension utilizing pre and post assessments
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☑Protect the general public from harm (environmental, criminal, etc.)	Opioid addicted individuals may engage in criminal behaviors in order to fund or procure narcotic medications or illicit substances to address their addiction disorder.	Recidivism data of those arrested for behaviors associated with their opioid addiction can be analyzed to assess intervention strategies.
☐Improve transportation conditions		
☑Increase or improve economic activity	Substance abuse such as opiate dependence or addiction can affect job productivity, absenteeism, and job loss rates which cumulatively affect	Tracking not feasible in pilot stage but tracking potential may be possible in furthered implementation and more

	the local economy.	robust data analysis.
☐Increase tourism		
☑Create specific immediate job opportunities	Peer Coaches will be hired.	Track number of unemployed rate prior to hire in the Peer Coach role.
☑Enhance specific individual?s economic self sufficiency	Peer Coaches may be individuals in receipt of disability due to their disorder, the role may provide income necessary to move off of disability benefits due to employment directly tied to their disability, overall improving their self economic sufficiency.	Tracked by employment agency.
☑Reduce recidivism	Arrest, emergency department, and detox recidivism will be reduced.	These data will be tracked in aggregate based on enrolled participants.
☑Reduce substance abuse	Peer Coach program is designed to reduce substance abuse frequency, amount, and varieties.	Overdose rates and fatal overdose rates in aggregate at community level and programmatic level based upon enrollment
☑Divert from Criminal/Juvenile justice system	Peer Coaching can provide support necessary to seek treatment thus reducing criminality of drug use behavior	Tracked in aggregate and at individual level based upon identified persons enrolled
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		

☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	500,000	50.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	500,000	50.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	1,000,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled Manatee County Opioid Addiction Recovery Peer Pilot Program; providing an appropriation; providing an effective date.

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

Section 1. Manatee County Opioid Addiction Recovery Peer Pilot Program is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 784, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $500,000 from the General Revenue Fund is appropriated to the Department of Children and Families to fund the Manatee County Opioid Addiction Recovery Peer Pilot Program as described in Appropriations Project Request 784. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: The Miracle League of Miami Dade
2. Date of Submission: 02/06/2017
3. House Member Sponsor: Jose Diaz
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					300,000	300,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Agency for Persons with Disabilities

6. Requester:
   a. Name: Karl Sturge
   b. Organization: The Miracle League of Miami-Dade, Inc.
   c. Email: karls1340@bellsouth.net
   d. Phone #: (305)251-4964

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Karl Sturge
   b. Organization: The Miracle League of Miami-Dade, Inc.
   c. Email: karls1340@bellsouth.net
   d. Phone #: (305)251-4964

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: None
   b. Firm: None
   c. Email:
   d. Phone #:

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: The Miracle League of Miami-Dade, Inc.
   b. County (County where funds are to be expended): Miami-Dade
   c. Service Area (Counties being served by the service(s) provided with funding): Miami-Dade

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

The construction of a baseball field, support structures and playground for children with special needs.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☐a. Executive Director/Project Head Salary and Benefits		
☐b. Other Salary and Benefits		
☐c. Expense/Equipment/Travel/Supplies/Other		
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☐e. Salaries and Benefits		
☐f. Expenses/Equipment/Travel/Supplies/Other		
☐g. Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation:		
☑h. Construction/Renovation/Land/Planning Engineering	Construction of a baseball field for special needs children	300,000
TOTAL		300,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

- ○For Profit
- ⊙Non Profit 501(c) (3)
- ○Non Profit 501(c) (4)
- ○Local Government (e.g., police, fire or local government buildings, local roads, etc.)
- ○State agency owned facility (For example: college or university facility, buildings for public schools, roads in the state transportation system, etc.)
- ○Other (Please describe)

14. Is the project request an information technology project?
No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?
Yes

15a. Please Describe:
Miami Marlins, Mayor Gimenez, Miami-Dade School Board

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?
Yes

16a. Please Describe:
Miami Dade County Parks

17. Will the requested funds be used directly for services to citizens?
Yes

17a. Describe the target population to be served. Select all that apply to the target population:

- ☑Elderly persons
- ☑Persons with poor mental health
- ☑Persons with poor physical health
- ☐Jobless persons
- ☑Economically disadvantaged persons

☑At-risk youth
☐Homeless
☑Developmentally disabled
☑Physically disabled
☐Drug users (in health services)
☑Preschool students
☑Grade school students
☑High school students
☑University/college students
☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☑Other (Please describe): Children who are fortunate enough not to have special needs will also participate as "buddies"

17b. How many in the target population are expected to be served?
○< 25
○25-50
○51-100
○101-200
○201-400
○401-800
⊙>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Allows the children to engage in physical activities that they would otherwise not participate in.	Allows the children to engage in physical activities that they would otherwise not participate in.
☐Improve mental health		
☐Enrich cultural experience		
☐Improve agricultural production/promotion/education		

☐Improve quality of education		
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☐Increase or improve economic activity		
☐Increase tourism		
☐Create specific immediate job opportunities		
☐Enhance specific individual?s economic self sufficiency		
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in

			writing?
1. Amount Requested from the State in this Appropriations Project Request:	300,000	34.1%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	60,000	6.8%	No
5. Other:	520,000	59.1%	No
TOTAL	880,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled The Miracle League of Miami Dade; providing an appropriation; providing an effective date.

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

Section 1. The Miracle League of Miami Dade is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 852, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $300,000 from the General Revenue Fund is appropriated to the Agency for Persons with Disabilities to fund the The Miracle League of Miami Dade as described in Appropriations Project Request 852. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Our Pride Academy, Inc.
2. Date of Submission: 02/03/2017
3. House Member Sponsor: Jose Diaz
   Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? Yes
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded? 2016-17
c. Were the funds provided in the most recent fiscal year subsequently vetoed? No
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:		1,200,000	1,200,000		1,200,000	1,200,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Agency for Persons with Disabilities

6. Requester:
   a. Name: Cristina Cartaya
   b. Organization: Our Pride Academy, Inc. OPA Works
   c. Email: ccartaya@ourprideacademy.org
   d. Phone #: (305)271-2678

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Cristina Cartaya
   b. Organization: Our Pride Academy, Inc. OPA Works
   c. Email: ccartaya@ourprideacademy.org
   d. Phone #: (305)271-2678

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Alex Villalobos
   b. Firm: Florida Legislative Research, LLC
   c. Email: avillalobos@meyerbrookslaw.com
   d. Phone #: (786)564-1104

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Our Pride Academy, Inc.
   b. County (County where funds are to be expended): Miami-Dade
   c. Service Area (Counties being served by the service(s) provided with funding): Broward, Miami-Dade, Monroe

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

Our Pride Academy, Inc. OPA Works Program has designed a work program that provide situations and experience to help program participants learn skills, gain confidence, build self-esteem and develop good work habits and attitudes to help them become employable. Some of the innovative features of our programs include: Customized employment opportunities, work experiences, and transition planning for each student/client, driven by their interests, support needs, strengths, and contributions

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☑a. Executive Director/Project Head Salary and Benefits	Director will oversee and train individuals with developmental and intellectual disabilities to gain the necessary skills for competitive employment, contract work, and/or become self-employed using an entrepreneurial model.	63,528
☑b. Other Salary and Benefits	CEO 30% admin, 7 managers will train individuals with developmental and intellectual disabilities to gain the necessary skills for competitive employment, contract work, and/or become self-employed using an entrepreneurial model. Indirect costs (10% for operating administrative overhead)	410,774

☑c. Expense/Equipment/Travel/Supplies/Other	Rent (12,500 sq.ft. class A bldg. @$20.00) Office supplies Payroll taxes admin	276,823
☑d. Consultants/Contracted Services/Study	Budget consultant Accounting services Audit services	25,000
Operational Costs:		
☑e. Salaries and Benefits	Bookkeeper 30% program, Community/Event coordinator 30% program., building maintenance 10% program, 7 job coaches will train individuals with developmental and intellectual disabilities to gain the necessary skills for competitive employment, contract work, and/or become self-employed using an entrepreneurial model.	187,698
☑f. Expenses/Equipment/Travel/Supplies/Other	Two 15 passenger vans to transport clients to and from jobs, start-up costs for the various programs. Program supplies Payroll taxes program Liability/property insurance Workman?s compensation Auto insurance Auto maintenance/gas License/taxes Postage Dues/subscriptions Telephone Printing Advertising Marketing Building maintenance Alarm monitoring Additional educational program Utilities	231,177
☑g. Consultants/Contracted Services/Study	Web designer for program	5,000

Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		1,200,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

This program has been supported by various agencies and foundations in Miami Dade County. Work for America, a non-profit organization working towards the employment of individuals with developmental and intellectual disabilities has been a monetary supporter. UM-CARD (UM ? Center for Autism and Related Disabilities) has supported the program by sending licensed therapists to work with individual clients. Florida International University sends students to mentor in the work program as well as

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

Yes

16a. Please Describe:

From the Office of the Governor Executive Order Number 13-284 and Executive Order Number 11-161 reaffirms the commitment to employment for Floridians with disabilities.

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☐Elderly persons

☐Persons with poor mental health

☐Persons with poor physical health
☑Jobless persons
☑Economically disadvantaged persons
☑At-risk youth
☐Homeless
☑Developmentally disabled
☑Physically disabled
☐Drug users (in health services)
☐Preschool students
☐Grade school students
☑High school students
☐University/college students
☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☑Other (Please describe): individuals with autism and related disorders

17b. How many in the target population are expected to be served?
○< 25
○25-50
⊙51-100
○101-200
○201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	By using physical activity to get out of the house and working.	Regular attendance. Mobility, weight control
☑Improve mental health	Using their cognitive abilities to learn skills and increase self-esteem.	Regular attendance and performance reviews.

☑Enrich cultural experience	Going into the community.	Sales and distribution
☐Improve agricultural production/promotion/education		
☑Improve quality of education	Continued education in all functional skills.	Academic curriculum
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☑Increase or improve economic activity	Becoming wage earners	Competitive employment (Publix) and/or self-employment.
☐Increase tourism		
☑Create specific immediate job opportunities	Small business models: OPA Candles & Such OPA Suds OPA Bistro	Sales, contract work, competitive employment
☑Enhance specific individual?s economic self sufficiency	Community based employment and/or self-employment opportunities.	Contributing to the tax base and reduce reliance on public funds.
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		

☐Improve drinking water quality		
☐Improve surface water quality		
☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	1,200,000	100.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	1,200,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
No

A bill to be entitled

An act relating to the Appropriations Project titled Our Pride Academy, Inc.; providing an appropriation; providing an effective date.

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

Section 1. Our Pride Academy, Inc. is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 681, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $1,200,000 from the General Revenue Fund is appropriated to the Agency for Persons with Disabilities to fund the Our Pride Academy, Inc. as described in Appropriations Project Request 681. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.

Appropriations Project Request - Fiscal Year 2017-18

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Center for Independent Living Central Florida, Inc. - Central Florida Health and Safety for Seniors Pilot Project
2. Date of Submission: 02/03/2017
3. House Member Sponsor: Gayle Harrell
   Members Copied: Joseph Abruzzo

4. DETAILS OF AMOUNT REQUESTED:

a. Has funding been provided in a previous state budget for this activity? No
   If answer to 4a is ?NO? skip 4b and 4c and proceed to 4d
b. What is the most recent fiscal year the project was funded?
c. Were the funds provided in the most recent fiscal year subsequently vetoed?
d. Complete the following Project Request Worksheet to develop your request (Note that column E will be the total of Recurring funds requested and Column F will be the total Nonrecurring funds requested, the sum of which is the Total of the Funds you are requesting in column G):

FY:	Input Prior Year Appropriation for this project for FY 2016-17 (If appropriated in 2016-17 enter the appropriated amount, even if vetoed.)			Develop New Funds Request for FY 2017-18 (Requests for additional RECURRING funds are prohibited. Any additional Nonrecurring funding requested to supplement recurring funds in the base will result in the base recurring amount being converted to Nonrecurring .)		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated (Recurring plus Nonrecurring: column A + column B)	Recurring Base Budget (Will equal non-vetoed amounts provided in Column A)	**Additional Nonrecurring Request**	**TOTAL Nonrecurring Request** (Will equal the amount from the Recurring base in Column D to be CONVERTED to Nonrecurring plus the Additional Nonrecurring Request in Column E. These funds will be appropriated non-recurring if funded in the House Budget or the Final Conference Report on the budget.)
Input Amounts:					375,000	375,000

5. Are funds for this issue requested in a state agency?s Legislative Budget Request submitted for FY 2017-18? No
   5a. If yes, which state agency?

5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? For example, if the requested issue pertains to services provided to inmates at correctional facilities, the Department of Corrections would be the most appropriate state agency. Department of Elder Affairs

6. Requester:
   a. Name: Elizabeth Howe
   b. Organization: Center for Independent Livin gin Central Florida, Inc.
   c. Email: ehowe@cilorlando.org
   d. Phone #: (407)623-1070

7. Contact for questions about specific technical or financial details about the project (Please retype if same as Requester):
   a. Name: Elizabeth Howe
   b. Organization: Center for Independent Livin gin Central Florida, Inc.
   c. Email: ehowe@cilorlando.org
   d. Phone #: (407)623-1070

8. If there is a registered lobbyist, fill out the lobbyist information below.
   a. Name: Georgia McKeown
   b. Firm: McKeown & Associates
   c. Email: georgia@gamckeown.com
   d. Phone #: (904)303-1611

9. Organization or Name of Entity Receiving Funds(Please retype if same as Requestor or Contact):
   a. Name: Center for Independent Living in Central Florida, Inc.
   b. County (County where funds are to be expended): Orange
   c. Service Area (Counties being served by the service(s) provided with funding): Orange

10. What type of organization is the entity that will receive the funds? (Select one)
   - O For Profit
   - ⊙ Non Profit 501(c) (3)
   - O Non Profit 501(c) (4)
   - O Local Government

O University or College
O Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

To promote independent living for seniors with disabilities, by providing home accessibility and fall prevention services and training and to prevent placement in nursing home facilities

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. F) Enter ?0? if request is zero for the category
Administrative Costs:		
☑a. Executive Director/Project Head Salary and Benefits	20% of project director's salary and benefits	15,000
☐b. Other Salary and Benefits		
☑c. Expense/Equipment/Travel/Supplies/Other	Includes administrative costs for insurance, travel, equipment and supplies.	10,000
☐d. Consultants/Contracted Services/Study		
Operational Costs:		
☑e. Salaries and Benefits	Two FTE direct service staff salaries and benefits.	97,000
☑f. Expenses/Equipment/Travel/Supplies/Other	Program expenses, supplies, travel, facilities and equipment.	153,750
☑g. Consultants/Contracted Services/Study	Home accessibility and fall prevention training contracted services	99,250

Fixed Capital Construction/Major Renovation:		
☐h. Construction/Renovation/Land/Planning Engineering		
TOTAL		375,000

13. For the Fixed Capital Costs requested with this issue, what type of ownership will the facility be under when complete? (In Question 12, if ?h. Fixed Capital Outlay? was not selected, question 13 is not applicable)

N/A

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Publix Charities Foundation, The Home Depot Foundation, Orange County Government all support the initiative.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

No

17. Will the requested funds be used directly for services to citizens?

Yes

17a. Describe the target population to be served. Select all that apply to the target population:

☑Elderly persons
☑Persons with poor mental health
☑Persons with poor physical health
☐Jobless persons
☑Economically disadvantaged persons
☐At-risk youth
☐Homeless
☑Developmentally disabled
☑Physically disabled

☐Drug users (in health services)
☐Preschool students
☐Grade school students
☐High school students
☐University/college students
☐Currently or formerly incarcerated persons
☐Drug offenders (in criminal Justice)
☐Victims of crime
☐Other (Please describe)

17b. How many in the target population are expected to be served?

○< 25
◉25-50
○51-100
○101-200
○201-400
○401-800
○>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select all that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
☑Improve physical health	Prevent falls and other injuries to seniors with disabilities living in their own homes.	Pre and post surveys to measure fall prevention success through training.
☑Improve mental health	Promote independence of senior citizens with disabilities by allowing them to continue living in their homes and remaining involved in their community, thereby improving their mental health and wellbeing.	Post survey at six months and one year to determine the number of individuals served with home accessibility services still residing in their own home.
☐Enrich cultural experience		

☐Improve agricultural production/promotion/education		
☐Improve quality of education		
☐Enhance/preserve/improve environmental or fish and wildlife quality		
☐Protect the general public from harm (environmental, criminal, etc.)		
☐Improve transportation conditions		
☑Increase or improve economic activity	Estimated savings to state of $2,650,000 by diverting Medicaid long term eligible individuals from nursing home placement.	The annual savings to the state of $52,500 per project participant times the humber of project participants is $52,500 X 50 = $2,650,000. Annual average cost per person is $52,500.
☐Increase tourism		
☐Create specific immediate job opportunities		
☐Enhance specific individual?s economic self sufficiency		
☐Reduce recidivism		
☐Reduce substance abuse		
☐Divert from Criminal/Juvenile justice system		
☐Improve wastewater management		
☐Improve stormwater management		
☐Improve groundwater quality		
☐Improve drinking water quality		
☐Improve surface water quality		

☐Other (Please describe):		

19. Provide the total cost of the project for FY 2017-18 from all sources of funding (Enter ?0? if amount is zero):

Type of Funding	Amount	Percent of Total (Automatically Calculates)	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	375,000	100.0%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	0	0.0%	No
5. Other:	0	0.0%	No
TOTAL	375,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?
Yes

20a. How much state funding would be requested after 2017-18 over the next 5 years?
- ⊙<1M
- ○1-3M
- ○>3-10M
- ○>10M

20b. How many additional years of state support do you expect to need for this project?
- ○1 year
- ⊙2 years
- ○3 years
- ○4 years
- ○>= 5 years

20c. What is the total project cost for all years including all federal, local, state, and any other funds? Select the single answer which best describes the total project cost. If funds requested are for ongoing services or for recurring activities, select ?ongoing activity?.

- ○ ongoing activity ? no total cost
- ○ <1M
- ◉ 1-2M
- ○ >2-3M
- ○ >3-10M
- ○ >10M

A bill to be entitled

An act relating to the Appropriations Project titled Center for Independent Living Central Florida, Inc. - Central Florida Health and Safety for Seniors Pilot Project; providing an appropriation; providing an effective date.

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

Section 1. Center for Independent Living Central Florida, Inc. - Central Florida Health and Safety for Seniors Pilot Project is an Appropriations Project as defined in The Rules of The Florida House of Representatives and is described in Appropriations Project Request 675, herein incorporated by reference.

Section 2. For fiscal year 2017-2018 the nonrecurring sum of $375,000 from the General Revenue Fund is appropriated to the Department of Elder Affairs to fund the Center for Independent Living Central Florida, Inc. - Central Florida Health and Safety for Seniors Pilot Project as described in Appropriations Project Request 675. Notwithstanding any law to the contrary, there shall be no recurring funding provided for this Appropriations Project.

Section 3. This act shall take effect July 1, 2017.