Health & Human Services Committee

Thursday, February 15, 2024
9:00 AM – 1:00 PM
Morris Hall (17 HOB)

Meeting Packet

Paul Renner
Speaker

Randy Fine
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time: Thursday, February 15, 2024 09:00 am

End Date and Time: Thursday, February 15, 2024 01:00 pm

Location: Morris Hall (17 HOB)

Duration: 4.00 hrs

Consideration of the following bill(s):

CS/HB 159 HIV Infection Prevention Drugs by Healthcare Regulation Subcommittee, Franklin
CS/HB 241 Coverage for Skin Cancer Screenings by Select Committee on Health Innovation, Massullo, Payne
HB 631 Aftercare Services Under Road-To-Independence Program by Tramont, Abbott
CS/HB 883 Short-acting Bronchodilator Use in Public and Private Schools by Choice & Innovation Subcommittee, Koster
CS/HB 891 Health Care Provider Accountability by Select Committee on Health Innovation, Giallombardo, Salzman
CS/HB 1063 Practice of Chiropractic Medicine by Healthcare Regulation Subcommittee, Hunschofsky
CS/HB 1219 Dental Insurance Claims by Insurance & Banking Subcommittee, Black
CS/HB 1259 Providers of Cardiovascular Services by Select Committee on Health Innovation, Andrade
CS/CS/HB 1267 Economic Self-sufficiency by Appropriations Committee, Children, Families & Seniors Subcommittee, Anderson
CS/HB 1269 Potency for Adult Personal Use of Marijuana by Healthcare Regulation Subcommittee, Massullo, Fine
CS/HB 1501 Health Care Innovation by Health Care Appropriations Subcommittee, Gonzalez Pittman
CS/HB 1549 Health Care by Health Care Appropriations Subcommittee, Grant
CS/HB 7021 Mental Health and Substance Abuse by Health Care Appropriations Subcommittee, Children, Families & Seniors Subcommittee, Maney
HB 7041 Public Records and Meetings Exemptions by Select Committee on Health Innovation, Andrade

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m. Wednesday, February 14, 2024.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, February 14, 2024.

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the “Visiting the House” tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 02/13/2024 4:14PM by Arnold.Sabrina

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 159 HIV Infection Prevention Drugs
SPONSOR(S): Healthcare Regulation Subcommittee, Franklin
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	14 Y, 0 N, As CS	Osborne	McElroy
2) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

Pharmacy is the third largest health profession in the US, following only nursing and medicine. In Florida, the Board of Pharmacy (BOP), in conjunction with the Department of Health (DOH), regulates the practice of pharmacy. Pharmacist's scope of practice includes the compounding, dispensing, and consulting of patients concerning contents, therapeutic values, and uses of a medicinal drug.

Human Immunodeficiency Virus (HIV) is an immune system debilitating virus that affects specific cells of the immune system and over time the virus can destroy so many of these cells that the body cannot fight off infections and disease. If not properly treated, HIV can lead to fatal acquired immunodeficiency syndrome (AIDS). According to the Centers for Disease Control and Prevention (CDC), an estimated 1.2 million people in the United States currently living with HIV.

Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are two biomedical prevention strategies for people without HIV. PrEP is taken before HIV exposure and for people who do not have HIV but are at a high risk of exposure to HIV, PrEP can be used to significantly reduce risk of HIV infection. PrEP is available in two forms: a daily oral medication and a long-acting injectable delivered once every two months. PEP is taken after a person has been exposed to HIV. PEP is intended for use in emergency situations, and is not meant for frequent use by people who are at high risk of HIV exposure. When taken within 72 hours of HIV exposure, PEP significantly reduces risk of HIV infection.

CS/HB 159 allows licensed pharmacists to screen adults for HIV exposure and provide the results of such screening. A pharmacist who has screened a patient for HIV must advise the patient to seek further medical consultation or treatment from a physician.

The bill also establishes a process by which a pharmacist may become certified to order and dispense postexposure prophylaxis under a collaborative practice agreement with a physician. The bill establishes minimum criteria for the certification which a pharmacist must obtain before they may order and dispense HIV infection prevention drugs. The bill outlines minimum requirements for the contents of the collaborative practice agreement, and requires pharmacies in which a pharmacist is providing services under such an agreement to submit an access-to-care plan to the BOP and DOH.

The bill directs the BOP to develop rules to implement the provisions of the bill.

The bill has an insignificant, negative fiscal impact on DOH, and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Pharmacist Licensure and Regulation

Pharmacy is the third largest health profession in the US, following only nursing and medicine.[1] The Board of Pharmacy (BOP), in conjunction with the Department of Health (DOH), regulates the practice of pharmacists pursuant to ch. 465, F.S. To be licensed as a pharmacist, a person must:[2]

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;[3]
- Have completed a Board-approved internship; and
- Successfully complete the Board-approved examination.

A pharmacist must complete at least 30 hours of Board-approved continuing education during each biennial renewal period.[4] Pharmacists who are certified to administer vaccines or epinephrine auto-injections must complete a three-hour continuing education course on the safe and effective administration of vaccines and epinephrine injections as a part of the biennial licensure renewal.[5] Pharmacists who administer long-acting antipsychotic medications must complete an approved eight-hour continuing education course as a part of the continuing education for biennial licensure renewal.[6] All pharmacists are required to complete a one-hour continuing education course on HIV/AIDS as a part of their first licensure renewal.[7]

Pharmacist Scope of Practice

In Florida, the practice of the profession of pharmacy includes:[8]

- Compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of a medicinal drug;
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations;
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy, including the review of the patient's drug therapy and communication with the patient's prescribing health care provider or other persons specifically authorized by the patient, regarding the drug therapy;
- Transmitting information from prescribers to their patients;
- Administering vaccines to adults;[9]
- Administering epinephrine injections;[10] and

[1] American Association of Colleges of Pharmacy, *About AACP*. Available at https://www.aacp.org/about-aacp (last visited January 31, 2024).
[2] S. 465.007, F.S.
[3] *Id*. If the applicant has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, the applicant must demonstrate proficiency in English, pass the board-approved Foreign Pharmacy Graduate Equivalency Examination, and complete a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a DOH-licensed pharmacist.
[4] S. 465.009, F.S.
[5] S. 465.009(6), F.S.
[6] S. 465.1893, F.S.
[7] See, Board of Pharmacy, *Pharmacist: Continuing Education Requirements*. Available at https://floridaspharmacy.gov/renewals/pharmacist/#tab-ce (last visited January 31, 2024).
[8] S. 465.003(13), F.S.
[9] *See* s. 465.189, F.S.
[10] *Id*.

- Administering antipsychotic medications by injection.[11]

A pharmacist may not alter a prescriber's directions, diagnose or treat any disease, initiate any drug therapy, or practice medicine or osteopathic medicine, unless permitted by law.[12]

Pharmacists may order and dispense drugs that are included in a formulary developed by a committee composed of members of the Board of Medicine, the Board of Osteopathic Medicine, and the BOP. The formulary may only include:[13]

- Any medicinal drug of single or multiple active ingredients in any strengths when such active ingredients have been approved individually or in combination for over-the-counter sale by the U.S. Food and Drug Administration (FDA);
- Any medicinal drug recommended by the FDA Advisory Panel for transfer to over-the-counter status pending approval by the FDA;
- Any medicinal drug containing any antihistamine or decongestant as a single active ingredient or in combination;
- Any medicinal drug containing fluoride in any strength;
- Any medicinal drug containing lindane in any strength;
- Any over-the-counter proprietary drug under federal law that has been approved for reimbursement by the Florida Medicaid Program; and
- Any topical anti-infectives, excluding eye and ear topical anti-infectives

A pharmacist may order the following, within his or her professional judgment and subject to the conditions established by rule:[14]

- Certain oral analgesics for mild to moderate pain. The prescription is limited to a six-day supply for one treatment of:
    - Magnesium salicylate/phenyltoloxamine citrate.
    - Acetylsalicylic acid (Zero order release, long acting tablets).
    - Choline salicylate and magnesium salicylate.
    - Naproxen sodium.
    - Naproxen.
    - Ibuprofen.
- Certain urinary analgesics, not exceeding a two (2) day supply;
- Otic analgesics. Antipyrine 5.4%, benzocaine 1.4%, glycerin, if clinical signs or symptoms of tympanic membrane perforation do not exist. The product shall be labeled for use in the ear only;
- Anti-nausea preparations;
- Certain antihistamines and decongestants;
- Certain topical antifungal;/antibacterial treatments;
- Topical anti-inflammatory treatments;
- Certain otic antifungal/antibacterial treatments.
- Keratolytics for the treatment of warts, except in patients under age two, or with diabetes or impaired circulation;
- Vitamins with fluoride, excluding vitamins with folic acid in excess of 0.9 mg;
- Medicinal shampoos containing lindane for the treatment of head lice;
- Certain ophthalmic solutions;
- Certain histamine H12 antagonists;
- Certain acne products; and
- Topical antiviral to treat herpes simplex infections of the lips.

[11] S. 465.1893, F.S.
[12] S. 465.003, F.S.
[13] S. 456.186, F.S.
[14] Rule 64B16-27.220, F.A.C.

Human Immunodeficiency Virus

Human Immunodeficiency Virus (HIV) is an immune system debilitating virus that affects specific cells of the immune system and over time the virus can destroy so many of these cells that the body cannot fight off infections and disease. If not properly treated, HIV can lead to acquired immunodeficiency syndrome (AIDS), the third and most severe stage of HIV infection. Without proper treatment, people with AIDS typically survive only three years.[15]

There is currently no effective cure for HIV. Once a person has HIV, they have it for life.[16] The symptoms and transmission of HIV can be mitigated through medication.[17] When HIV is controlled through medication, the risk of transmission is close to zero. People who have HIV and are not on medication and do not have consistent control of their HIV can transmit the virus through sex, sharing of needles used for IV drug use, pregnancy, and breastfeeding.[18]

A person can mitigate their risk of contracting HIV through various prevention strategies. Using condoms correctly during every sexual encounter, not using intravenous drugs, and if you do, using clean needles significantly reduce one's risk for contracting HIV. For pregnant women with HIV, taking the appropriate HIV medication reduces the change of transmitting HIV to the infant to less than one percent.[19]

According to the Centers for Disease Control and Prevention (CDC), an estimated 1.2 million people in the United States currently living with HIV.[20] HIV disproportionately impacts certain segments of the US population, particularly those who live in the Southern US, including Black and Hispanic Americans, men who have sex with men, transgender people, people who use drugs, and rural communities.[21]

PrEP and PEP

Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are two biomedical prevention strategies for people without HIV. "Prophylaxis" means to prevent or control the spread of an infection of disease, and pre- and post-exposure refers to when the treatment is taken in relation to HIV exposure.

PrEP is taken before HIV exposure and for people who do not have HIV but are at a high risk of exposure to HIV, PrEP can be used to significantly reduce risk of contracting HIV. A person may have a high risk of exposure to HIV through sex with a partner who is HIV-positive or through IV drug use. PrEP is available in two forms: a daily oral medication and a long-acting injectable delivered once every two months. Studies have shown that consistent use of PrEP reduces the risk of contracting HIV from sex by approximately 99 percent, and from IV drug use by at least 74 percent.[22]

PEP is a medication that is taken soon after exposure to HIV to prevent HIV infection in people who are HIV negative or do not know their HIV status. PEP must be taken within 72 hours of exposure, and should

[15] Centers for Disease Control and Prevention, *About HIV*. Available at https://www.cdc.gov/hiv/basics/whatishiv.html (last visited January 31, 2024).
[16] *Id*.
[17] Medications for treating HIV help people with HIV live longer, healthier lives, and reduce the risk of HIV transmission. However, they can have significant side effects, and different people may react to the same medication very differently. For more information on HIV medications and their side effects, see, National Institutes of Health (NIH), *Side Effects of HIV Medicines* (2021). Available at https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-medicines-and-side-effects (last visited February 2, 2024).
[18] National Institutes of Health (NIH), *HIV and AIDS: The Basics* (2023). Available at https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-aids-basics (last visited January 31, 2024).
[19] National Institutes of Health (NIH), *The Basics of HIV Prevention* (2023). Available at https://hivinfo.nih.gov/understanding-hiv/fact-sheets/basics-hiv-prevention (last visited January 31, 2024).
[20] Centers for Disease Control and Prevention, *HIV Surveillance Report: Estimated HIV Incidence and Prevalence in the United States, 2015-2019* (2021). Available at https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-26-1.pdf (last visited January 31, 2024).
[21] Centers for Disease Control and Prevention, *HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2021* (2023). Available at https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-34/index.html (last visited January 31, 2024). For more information on the growing prevalence of HIV in rural communities, *see*, Schafer, et al., *The Continuum of HIV Care in Rural Communities in the United States and Canada: What Is Known and Future Research Directions* (2019). Journal of Acquired Immune Deficiency Syndrome, 75(1): 35-44. doi: 10.1097/QAI.0000000000001329
[22] National Institutes of Health (NIH), *Pre-Exposure Prophylaxis (PrEP)* (2023). Available at https://hivinfo.nih.gov/understanding-hiv/fact-sheets/pre-exposure-prophylaxis-prep (last visited January 31, 2024).

be taken as soon after exposure as possible. PEP is intended for use in emergency situations, and is not meant for frequent use by people who are at high risk of HIV exposure. PEP is taken for 28 days following HIV exposure.[23]

PEP may be prescribed to someone who, in the last 72 hours:[24]

- May have been exposed to HIV during sex;
- Shared needles or other equipment to inject drugs;
- Were sexually assaulted; or
- May have been exposed to HIV at work.[25]

PEP is the only HIV prevention method that can be taken after exposure to HIV. When treatment is started within 72 hours of exposure, PEP is estimated to be more than 90 percent effective.[26]

At least 12 states have passed legislation allowing pharmacists to directly administer either PrEP or PEP to patients under certain circumstances.[27]

Effect of the Bill

CS/HB 159 allows licensed pharmacists to screen adults for HIV exposure and provide the results of such screening. A pharmacist who has screened a patient for HIV must advise the patient to seek further medical consultation or treatment from a physician. The bill also establishes a process by which a pharmacist may become certified to order and dispense postexposure prophylaxis under a collaborative practice agreement with a physician. Postexposure prophylaxis (PEP) is a drug or drug combination that meets the clinical eligibility recommendations of the United States Centers for Disease Control and Prevention guidelines for antiretroviral treatment following potential exposure to HIV.

Certification

The bill requires a pharmacist to be certified by the BOP before they order and dispense PEP under a collaborative practice agreement with a physician. The BOP, in conjunction with the Board of Medicine and Board of Osteopathic Medicine, must adopt rules for the certification. To be certified, a pharmacist must, at a minimum:

- Hold an active and unencumbered license to practice pharmacy;
- Be engaged in the active practice of pharmacy;
- Have earned a doctorate of pharmacy degree or have completed at least 3 years of experience as a licensed pharmacist;
- Maintain at least $250,000 of liability coverage;[28] and
- Have completed a course approved by the board, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, which includes, at a minimum, instruction on all of the following:
    - Performance of patient assessments;
    - Point-of-care testing procedures;
    - Safe and effective treatment of HIV exposure with HIV infection prevention drugs; and
    - Identification of contraindications and comorbidities.

Collaborative Practice Agreement

[23] National Institutes of Health (NIH), *Post-Exposure Prophylaxis (PEP)* (2021). Available at https://hivinfo.nih.gov/understanding-hiv/fact-sheets/post-exposure-prophylaxis-pep (last visited January 31, 2024).
[24] *Id*.
[25] Occupational exposure to HIV is very rare. For more information, see, Centers for Disease Control and Prevention, *HIV and Occupational Exposure* (2019). Available at https://www.cdc.gov/hiv/workplace/healthcareworkers.html (last visited January 31, 2024).
[26] Ayieko, J., Petersen, M. L., Kamya, M. R., & Havlir, D. V., *PEP for HIV prevention: are we missing opportunities to reduce new infections?* (2022). Journal of the International AIDS Society, 25(5), e25942. https://doi.org/10.1002/jia2.25942
[27] The states include Arkansas, California, Colorado, Illinois, Maine, Nevada, New Mexico, North Carolina, Oregon, Utah, and Virginia. *See*, NASTAD, *Pharmacist Authority to Initiate PrEP & PEP and Participate in Collaborative Practice Agreements*. (2023). Available at https://nastad.org/sites/default/files/2023-08/PDF-Pharmacist-Authority-Initiate-PrEP-PEP.pdf (last visited January 31, 2024).
[28] A pharmacist who maintains liability coverage pursuant to ss. 465.1865 or 465.1895, F.S. satisfies this requirement.

The bill allows a certified pharmacist to order and dispense PEP pursuant to a written collaborative practice agreement between the pharmacist and a licensed allopathic or osteopathic physician. The written collaborative practice agreement must include, at a minimum, the following:

- Terms and conditions relating to the screening for HIV and the ordering and dispensing of PEP by the pharmacist.;
- Specific categories of patients the pharmacist is authorized to screen for HIV and for whom the pharmacist may order and dispense PEP;
- The physician's instructions for obtaining relevant patient medical history for the purpose of identifying disqualifying health conditions, adverse reactions, and contraindications to the use of PEP;
- A process and schedule for the physician to review the pharmacist's actions under the practice agreement;
- Evidence of the pharmacists' current certification by the board; and
- Any other requirements as established by the BOP in consultation with the Board of Medicine and the Board of Osteopathic Medicine.

The physician partner is responsible for reviewing the pharmacist's actions to ensure compliance with the agreement. The bill requires that the pharmacist partner submit a copy of the written collaborative practice agreement to the BOP.

A pharmacist who orders and dispenses PEP under a collaborative practice agreement must provide the patient with written information advising the patient to seek follow-up care from the patient's primary care physician. If the patient indicates that they lack regular access to primary care, the bill requires the pharmacist to comply with the procedures of the pharmacy's access-to-care plan described below.

Access-to-Care Plan

The bill requires that a pharmacy wherein a pharmacist is providing services under such a collaborative practice agreement to submit an access-to-care plan (ACP) to the BOP and DOH annually. The ACP assists patients in gaining access to appropriate care settings if they present to the pharmacy for HIV screening and indicate that they lack regular access to primary care. The bill requires that an ACP include:

- Procedures to educate such patients about care that would be best provided in a primary care setting and the importance of receiving regular primary care; and
- The pharmacy's plan for collaborative partnership with one or more nearby federally qualified health centers, county health departments, or other primary care settings. The goals of such partnership must include, but need not be limited to, protocols for identifying and appropriately referring a patient who has presented to the pharmacy for HIV screening or access to HIV infection prevention drugs and indicates that he or she lacks regular access to primary care.

The bill directs the BOP to adopt rules to implement the provisions of the bill.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 465.1861, F.S., relating to ordering and dispensing HIV infection prevention drugs.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
   None.

2. Expenditures:
   The bill has an insignificant, negative fiscal impact on DOH that can be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:
   None.

2. Expenditures:
   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:
   None.

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:
   The bill provides sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:
   None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 1, 2024, the Healthcare Regulation Subcommittee adopted an amendment to HB 159 and reported the bill favorably as a committee substitute. The amendment:

- Removed provisions of the bill that would allow pharmacists to order and dispense PrEP drugs.
- Removed provisions of the bill relating to a statewide drug therapy protocol.
- Allows a pharmacist to screen an adult for HIV exposure and advise the adult to seek medical consultation from a physician.
- Allows a certified pharmacist to order and dispense PEP drugs pursuant to a written collaborative practice agreement between the pharmacist and a licensed physician, and outlines specific requirements for such collaborative practice agreement.
- Requires certain pharmacies to submit an access-to-care plan to DOH and the Board of Pharmacy, and outlines the requirements for an access-to-care plan.

The analysis is drafted to the bill as amended by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to HIV infection prevention drugs; creating s. 465.1861, F.S.; defining terms; authorizing licensed pharmacists to screen for HIV exposure and order and dispense HIV infection prevention drugs under a collaborative practice agreement; requiring pharmacists to be certified by the Board of Pharmacy before ordering and dispensing HIV infection prevention drugs; requiring the board, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, to adopt rules for such certification; specifying minimum requirements for the certification; requiring the board to adopt rules; providing an effective date.

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

Section 1. Section 465.1861, Florida Statutes, is created to read:

465.1861 Ordering and dispensing HIV infection prevention drugs.—

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

(a) "HIV" means the human immunodeficiency virus.

(b) "HIV infection prevention drug" means preexposure prophylaxis, postexposure prophylaxis, and any other drug

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

approved by the United States Food and Drug Administration for the prevention of HIV infection.

(c) "Postexposure prophylaxis" means a drug or drug combination that meets the clinical eligibility recommendations of the United States Centers for Disease Control and Prevention guidelines for antiretroviral treatment following potential exposure to HIV.

(d) "Preexposure prophylaxis" means a drug or drug combination that meets the clinical eligibility recommendations of the United States Centers for Disease Control and Prevention guidelines for antiretroviral treatment for the prevention of HIV transmission.

(2) A pharmacist may screen an adult for HIV exposure and provide the results to the adult, with the advice that the patient should seek further medical consultation or treatment from a physician.

(3) A pharmacist may dispense HIV preexposure prophylaxis drugs pursuant to a valid prescription issued by a licensed health care practitioner authorized by law to prescribe such drugs.

(4) A pharmacist who is certified under subsection (6) may order and dispense HIV postexposure prophylaxis drugs pursuant to a written collaborative practice agreement between the pharmacist and a physician licensed under chapter 458 or chapter 459.

(a) A written collaborative practice agreement between a pharmacist and a physician under this section must include, at a minimum, all of the following:

1. Terms and conditions relating to the screening for HIV and the ordering and dispensing of HIV postexposure prophylaxis drugs by the pharmacist. Such terms and conditions must be appropriate for the pharmacist's training.

2. Specific categories of patients the pharmacist is authorized to screen for HIV and for whom the pharmacist may order and dispense HIV postexposure prophylaxis drugs.

3. The physician's instructions for obtaining relevant patient medical history for the purpose of identifying disqualifying health conditions, adverse reactions, and contraindications to the use of HIV postexposure prophylaxis drugs.

4. A process and schedule for the physician to review the pharmacist's actions under the practice agreement.

5. Evidence of the pharmacist's current certification by the board as provided in subsection (6).

6. Any other requirements as established by the board in consultation with the Board of Medicine and the Board of Osteopathic Medicine.

(b) A physician who has entered into a written collaborative practice agreement pursuant to this section is responsible for reviewing the pharmacist's actions to ensure

compliance with the agreement.

(c) The pharmacist shall submit a copy of the written collaborative practice agreement to the board.

(5) A pharmacist who orders and dispenses HIV postexposure prophylaxis drugs pursuant to subsection (4) must provide the patient with written information advising the patient to seek follow-up care from his or her primary care physician. If the patient indicates that he or she lacks regular access to primary care, the pharmacist must comply with the procedures of the pharmacy's approved access-to-care plan as provided in subsection (7).

(6) To provide services under a collaborative practice agreement pursuant to this section, a pharmacist must be certified by the board, according to rules adopted by the board in consultation with the Board of Medicine and the Board of Osteopathic Medicine. To be certified, a pharmacist must, at a minimum, meet all of the following criteria:

(a) Hold an active and unencumbered license to practice pharmacy under this chapter.

(b) Be engaged in the active practice of pharmacy.

(c) Have earned a degree of doctor of pharmacy or have completed at least 3 years of experience as a licensed pharmacist.

(d) Maintain at least $250,000 of liability coverage. A pharmacist who maintains liability coverage pursuant to s.

465.1865 or s. 465.1895 satisfies this requirement.

(e) Have completed a course approved by the board, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, which includes, at a minimum, instruction on all of the following:

1. Performance of patient assessments.

2. Point-of-care testing procedures.

3. Safe and effective treatment of HIV exposure with HIV infection prevention drugs, including, but not limited to, consideration of the side effects of the drug dispensed and the patient's diet and activity levels.

4. Identification of contraindications.

5. Identification of patient comorbidities in individuals with HIV requiring further medical evaluation and treatment, including, but not limited to, cardiovascular disease, lung and liver cancer, chronic obstructive lung disease, and diabetes mellitus.

(7)(a) A pharmacy in which a pharmacist is providing services under a written collaborative practice agreement pursuant to subsection (4) must submit an access-to-care plan to the board and department annually.

(b) An access-to-care plan shall assist patients in gaining access to appropriate care settings when they present to the pharmacy for HIV screening and indicate that they lack regular access to primary care. An access-to-care plan must

include:

1. Procedures to educate such patients about care that would be best provided in a primary care setting and the importance of receiving regular primary care.

2. The pharmacy's plan for collaborative partnership with one or more nearby federally qualified health centers, county health departments, or other primary care settings. The goals of such partnership must include, but need not be limited to, protocols for identifying and appropriately referring a patient who has presented to the pharmacy for HIV screening or access to HIV infection prevention drugs and indicates that he or she lacks regular access to primary care.

(8) The board shall adopt rules to implement this section.

Section 2. This act shall take effect July 1, 2024.

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 & Human Services Committee

Representative Franklin offered the following:

Amendment

Remove lines 124-135 and insert:

a pharmacist for HIV screening and indicate that they lack regular access to primary care. An access-to-care plan must include:

1. Procedures to educate such patients about care that would be best provided in a primary care setting and the importance of receiving regular primary care.

2. The pharmacy's plan for collaborative partnership with one or more nearby federally qualified health centers, county health departments, or other primary care settings. The goals of such partnership must include, but need not be limited to,

protocols for identifying and appropriately referring a patient who has presented to the pharmacist for HIV screening or access to

CS/HB 241

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 241 Coverage for Skin Cancer Screenings
SPONSOR(S): Select Committee on Health Innovation, Massullo and Payne
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 56

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	14 Y, 0 N, As CS	Lloyd	Calamas
2) Appropriations Committee	24 Y, 0 N	Helpling	Pridgeon
3) Health & Human Services Committee		Lloyd	Calamas

SUMMARY ANALYSIS

Florida's state employee health coverage is managed by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). Under the authority of s. 110.123, F.S., the DSGI procures the benefits contracts, and manages the state's benefits program (Program) for over 300,000 state employees, their spouses, and dependents.

Cancer is the second leading cause of death in the United States and skin cancer deaths represent five percent of all cancer deaths. Over 9,600 new cases of skin cancer in Florida are diagnosed every year; however, the long term survival rates of those diagnosed are high with early detection.

CS/HB 241 requires contracted state group health insurance plans or health maintenance organizations (HMOs) to provide coverage and payment, without the imposition of a deductible, copayment, coinsurance, or any other cost sharing requirement, an annual skin cancer screening by a dermatologist licensed under chapters 458 or 459, a physician assistant licensed under chapters 458 or 459, or an advanced practice registered nurse who is under the supervision of a dermatologist licensed under chapters 458 and 459, F.S. DSGI oversees the day to day operations of the State Group Program.

Additionally, the bill prohibits the DSGI-contracted health plans from bundling a payment for a skin cancer screening with any other procedure or service, including an evaluation or management visit, which is performed during the same office visit or subsequent office visit.

The bill has a significant negative fiscal impact on the state employee group health plan, and no impact on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Skin Cancer

Cancer is the second most common cause of death in the United States after heart disease and in 2023, a total of 1.9 million new cancer cases were diagnosed.[1] Of the estimated new cancer cases in the United States, five percent were skin cancer cases.[2]

Florida's 2023 rates show an estimated number of 162,410 total new cases and 47,410 deaths for all cancer types. The actual number of cases is not known as skin cancer diagnoses are not required to be reported to cancer registries.[3]

There are two main types of cancer: nonmelanoma or keratinocyte carcinoma which includes squamous cell carcinoma (SCC) and basal cell carcinoma and melanoma.[4] The most common types are the nonmelanoma types and most of these cancers can be cured.

Cutaneous melanoma can occur on any part of the skin. Unusual moles, exposure to sunlight, and health history can affect a person's risk of melanoma.[5] In men, melanoma is often found in the area from the shoulders to the hips, or the head and neck. In women, it is most often found on the arms and legs.[6] However, melanoma may also occur in the eyes. When it does occur in the eyes, it is known either intraocular or ocular melanoma.

Ocular melanoma (OM) is the most common primary eye tumor in adults and nearly 2,000 new cases are diagnosed each year in the United States, second only to cutaneous melanoma.[7] Intraocular melanoma is a type of melanoma that forms in the tissues of the eyes and is a rare cancer.[8] Risk factors for this particular disease including having a fair complexion, being of an older age, and being white.[9] Ocular melanoma is most commonly diagnosed around age 55 and will metastasize to another organ in about half of all cases.[10] In 90 percent of cases where the tumor does metastasize, it first spreads to the liver.[11] While there is no known cure for OM, several treatment options are available depending on the patient's status and symptoms, including watchful waiting, surgery, or radiation therapy.[12]

More than 1.4 million people were identified in the United States in 2020 as living with this cancer.[13] Men and women are diagnosed with skin cancer at starkly different rates. The rate of new cases per

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[1] American Cancer Society, *Incidence Drops for Cervical Cancer But Rises for Prostate Cancer (January 12, 2024),* available at https://www.cancer.org/research/acs-research-news/facts-and-figures-2023.html (last viewed January 13, 2024).
[2] Id.
[3] American Cancer Society, *Cancer Facts & Figures 2023,* p. 25, available at Cancer Facts & Figures 2023 (last viewed January 13, 2024).
[4] National Cancer Institute, *Skin Cancer Screening (PDQ) – Patient Version,* available at Skin Cancer Screening - NCI (last viewed January 10, 2024).
[5] National Cancer Institute, *Melanoma Treatment (PDQ) – Patient Version,* available at Melanoma Treatment - NCI (cancer.gov) (last viewed January 12, 2024).
[6] Id.
[7] Melanoma Research Foundation, *Ocular Melanoma Fact Sheet (August 13, 2019),* available at Ocular Melanoma Fact Sheet (flippingbook.com) (last viewed January 12, 2024).
[8] National Cancer Institute, *Melanoma Treatment (PDQ) – Patient Version,* available at Melanoma Treatment - NCI (cancer.gov) (last viewed January 12, 2024).
[9] Id.
[10] Id.
[11] Melanoma Research Foundation, *Ocular Melanoma Patient Guide,* p.14, available at https://online.flippingbook.com/view/745990/16-17/ (last viewed January 12, 2024).
[12] Supra, note 8.
[13] National Cancer Institute, *Cancer Stat Facts: Melanoma of the Skin,* available at https://seer.cancer.gov/statfacts/html/melan.html (last viewed January 12, 2024).

100,000 persons for the time period of 2016-2020 for males was 26.9 and for females was 16.7.[14] Incidence rates are higher in women than in men before age 50, but after that the incident rates are increasingly higher in men. These trends have been associated with age differences in historical occupational and recreational exposure to ultraviolet radiation (UV) for men, increased use of indoor tanning among young women, and improvements in early detection practices over time.[15]

Differences by race and ethnicity in the number of new cases of cancer nationally are also present, as the chart below shows.[16]

Rate of New Cases per 100,000 Persons by Race/Ethnicity & Sex: Melanoma of the Skin

MALES	
All Races	26.9
Hispanic	4.5
Non-Hispanic American Indian/Alaska Native	8.7
Non-Hispanic Asian/Pacific Islander	1.3
Non-Hispanic Black	1.0
Non-Hispanic White	37.9

FEMALES	
All Races	16.7
Hispanic	4.3
Non-Hispanic American Indian/Alaska Native	7.8
Non-Hispanic Asian/Pacific Islander	1.1
Non-Hispanic Black	0.9
Non-Hispanic White	25.2

SEER 22 2016–2020, Age-Adjusted

National estimates for the probability of developing skin cancer over one's lifetime is 2.9 percent which is the sixth highest behind uterine (3.1 percent), colorectum (4.1 percent), lung and bronchus (6 percent), prostate (12.6 percent), and breast (12.9 percent).[17]

The long term survival rate is high for those diagnosed with skin cancer after five years at 93.5 percent. The more localized the cancer is when it is found, meaning the cancer has been confined to a primary spot, the higher the survival rate is compared to a cancer that has spread to the regional lymph nodes or metastasized to another region of the body.[18]

Skin Cancer in Florida

For Florida, the estimated new cases of skin cancer are 9,640 with projected deaths at 680 individuals.[19] The state's incidence rate was calculated at 25.70, indicating the number of diagnoses

[14] American Cancer Society, Cancer Statistic Center, *Probability of Developing or Dying of Cancer, by Type (data run on January 13, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 13, 2024).
[15] American Cancer Society, *Cancer Facts & Figures 2023,* p. 25, available at Cancer Facts & Figures 2023, (last viewed January 12, 2024).
[16] Id.
[17] Id.
[18] National Cancer Institute, Cancer Stat Facts: Melanoma of the Skin, *Survival by State,* available at https://seer.cancer.gov/statfacts/html/melan.html (last viewed January 12, 2024).
[19] American Cancer Society, Cancer Statistics Center, *Estimated New Cancer Cases and Deaths by States (sexes combined, Florida) (data run on January 13, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 13, 2024).

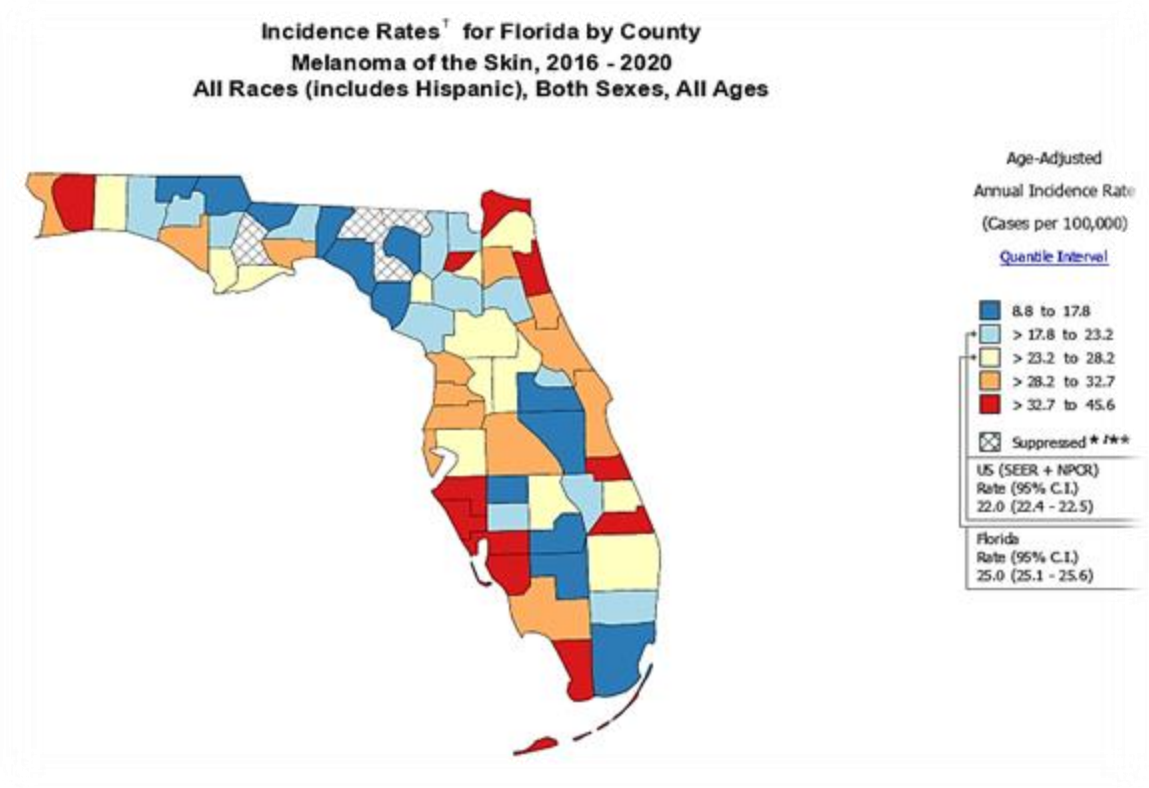
per 100,000 individuals.[20] In 2020, 4,477 new cases were reported for males and 2,770 cases for women.[21] Hospitalization rates and cost data for Florida are illustrated in the chart below.

Skin Cancer – Comparisons by Sex – Florida Only[22]				
	# of Hospitalizations	Total and Length of Stay Per Hospitalization	Median Length of Stay Per Hospitalization	Total Charges (in millions)
All Cancers	72,456	441,678	4.0	$8,632.7
Melanoma TOTAL:	136	594	2.0	$12.1
Female	41	184	4.0	$3.5
Male	95	410	2.0	$8.6

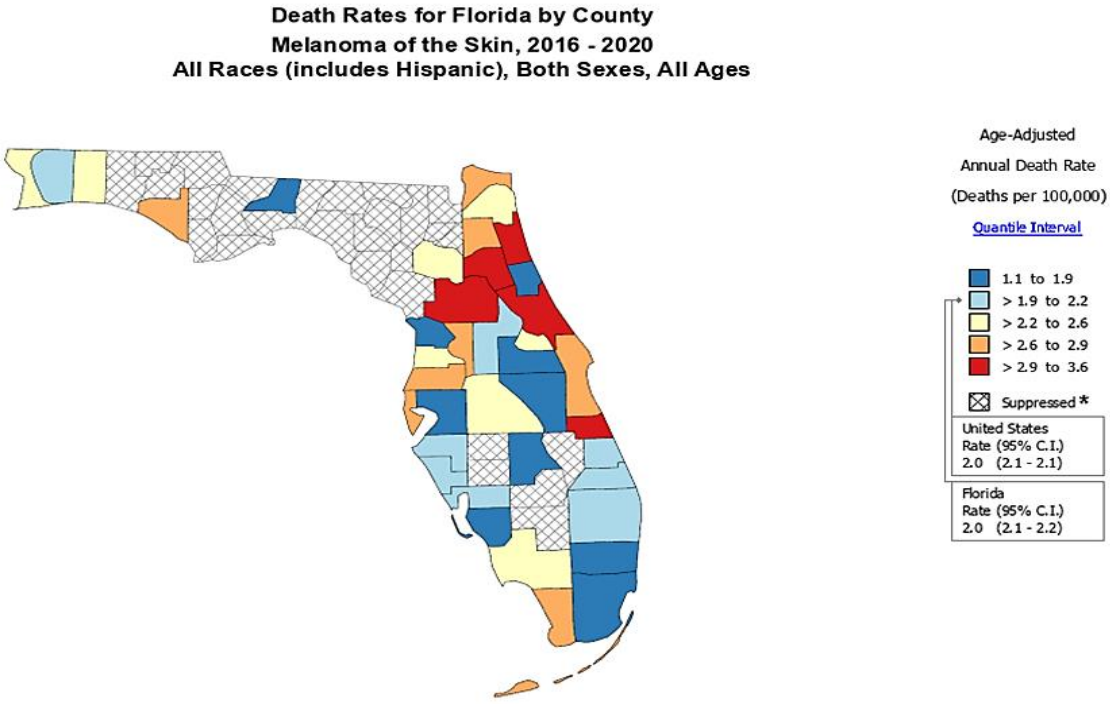
From a national perspective, Florida ranks 17th for the rate of melanoma per 100,000 people and 30th when compared to other states for mortality rates.[23] Increased exposure to UV radiation from the sun, and indoor or outdoor tanning beds are major risks for skin cancer and Floridians may carry a higher likelihood of such risks than individuals in other states. Other artificial sources of UV radiation include mercury vaping lighting which is usually found in stadiums and school gyms, some halogen, florescent and incandescent lights, and a few types of lasers.[24]

A few Florida counties have significantly higher incident rates for skin cancer with rates that fall in the 32.7 to 45.6 per 100,000 per incident rate.[25] Statistical models used by the National Cancer Institute show that new cases are on the rise at the rate of 1.2 percent per year nationally from 2010 through 2019, but for the period of time of 2015 through 2020, Florida's incident rate has remained stable.

[20] American Cancer Society, Cancer Statistics Center, *Incidence Rates by State and By Type (data run on January 13, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 13, 2024).
[21] Florida Cancer Data System, *Table 1:Number of New Cancer Cases by Sex and Race,* available at https://fcds.med.miami.edu/downloads/FloridaAnnualCancerReport/2020/Table_No_T1_(2020).pdf (last viewed January 11, 2024).
[22] Florida Cancer Data System, *Tables 33 – 38: Number of Cancer Hospitalizations by Sex,* reports generated at https://fcds.med.miami.edu/inc/statistics_data_vizf.shtml (last viewed January 12, 2024).
[23] American Cancer Society, Cancer Statistic Center, *Cancer Statistic Center,* available at Cancer Statistics Center - American Cancer Society (last viewed January 14, 2024). .
[24] Centers for Disease Control and Prevention, *UV Radiation, available at https://www.cdc.gov/nceh/features/uv-radiation-safety/index.html* (last viewed January 10, 2024).
[25] National Cancer Institute, *Interactive Maps – Incident Rates for Florida by County, Melanoma of the Skin, 2016 – 2020, All Races (includes Hispanic), Both Sexes, All Ages,* report can be re-generated at Interactive Maps (cancer.gov), (last viewed January 10, 2024).



A corresponding map showing the death rate by county reflects a different set of counties. The grouping of counties in southwestern Florida are in one of the lowest death rate quartiles meaning those counties have fewer residents who were diagnosed succumb to death because of that diagnosis. Likewise, many of the southeastern Florida counties have also fallen into the lower death rates as shown in the next figure.[26]



[25]Id.

Skin Cancer Screening

During a skin cancer screening test, a doctor or nurse checks a patient's skin for moles, birthmarks, or other pigmented areas that may be abnormal in color, size, shape, or texture. If an area looks abnormal, a biopsy of the area may be done where the health care provider may remove as much of the suspicious tissue as possible with a local excision. A pathologist reviews this tissue under a microscope to check for cancer cells.[27]

The American Academy of Dermatologists (AAD) encourages everyone to perform skin self-exams for signs of skin cancer and to get an exam from a doctor, especially if a new spot is found, or an existing spot changes, bleeds, or itches.[28] Individuals with a history of melanoma should have a full-body exam by a board-certified dermatologist at least annually and perform regular self-exams to check for any changes. A *Body Mole Map* is available on the AAD website which allows an individual to record a response for each of the A, B, C, D, and E components discussed below and to record the location of the spot on one sheet.[29]

The American Melanoma Foundation provides a "Record Your Spots" self-check body map on its website to help individuals document any new or changing areas. The AAD also has an infographic to assist individuals with self-checking through the ABCDEs of Melanoma. For each letter, the individual is reminded to look for a warning sign:

- A stands for asymmetry; does one half of the spot look different than the other?
- B stands for border; does the spot have an irregular, scalloped, or poorly defined border?
- C stands for color; does the spot have varying colors from one area to the next?
- D stands for diameter; what is the size?
- E stands for evolving; does the spot look different from the rest or is it changing in size, shape, or color?

The United States Preventive Services Task Force (USPSTF) is a volunteer board of national experts in prevention and evidence-based medicine who make recommendations using letters grades (A, B, C, D or I) after a review of the evidence and the balance of benefits and harms of a preventive service.[30] In April 2023, the USPST issued its final recommendations on screening for skin cancer and determined that there was not enough evidence to recommend for or against screening all individuals without symptoms. As a result, the recommendation, received an "I" grade.[31] The Task Force noted that evidence on screening is limited and Task Force members wanted the recommendation to draw attention to more culturally diverse research and to be reflective of the nation's population.[32,33] Because

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[27] National Cancer Institute, *Skin Cancer Screening (PDQ) – Patient Version,* available at Skin Cancer Screening - NCI (last viewed January 12, 2024).
[28] American Academy of Dermatologists, *Infographic: How to Spot Skin Cancer, Infogra https://www.aad.org/public/diseases/skin-cancer/how-to-spot-skin-cancer phic: How to SPOT Skin Cancer™ (aad.org),* (last viewed January 12, 2024).
[29] American Academy of Dermatology, *Infographic: Skin Cancer Body Mole Map,* available at https://www.aad.org/public/diseases/skin-cancer/find/mole-map (last viewed January 12, 2024).
[30] An "A" grade means the USPSTF recommends the service and there is a high certainty that the net benefit of the service is substantial. A service with a "B" grade is also recommended, and there is a finding of a high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.[30] A service or screening receiving a "C" grade is recommended to be offered selectively or to be provided to patients based on professional judgment and patient preferences. There is at least a moderate certainty that the net benefit is small. A "D" grade reflects the task force's recommendation against the service finding moderate or high certainty that the service has no net benefit or that the harms outweigh the risks. U.S. Preventive Services Task Force, *Grade Definitions after July 2012,* available at https://www.uspreventiveservicestaskforce.org/apps/gradedef.jsp (last viewed January 12, 2024).
[31] An "I" grade by the USPSTF means the task force concluded that current evidence is inconclusive to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefit and harms cannot be determined. United States Prevention Services Task Force, *U.S. Preventive Services Task Force Issues Final Recommendation on Screening for Skin Cancer (April 18, 2023),* available at https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/skin-cancer-screening-final-rec-bulletin.pdf (last viewed January 13, 2024).
[32] Id.
[33] 45 CFR 156.100. et seq.

the USPSTF did not give skin cancer screening for all individuals an "A" or "B" grade, these screenings are not required to be covered under the PPACA essential health benefits as preventive services.[34]

While not recommending these screenings for individuals without symptoms or a family history, the USPSTF does recommend counseling in selected situations. Through a *Behavioral Counseling to Prevent Skin Cancer Recommendation Statement* which has been in place since 2018,[35] the USPSTF did award a "B" grade for counseling of young adults, adolescents, children, and parents of young children to minimize exposure to UV radiation for persons aged six months to 24 years with fair skin types to reduce their risk of skin cancer. [36] As a screening or guidelines recommended by the USPSTF with a B grade, this counseling service is identified as a covered preventive service without cost sharing currently.

For adults older than age 24 with fair skin types, the recommendation to clinicians was to selectively offer counseling about minimizing exposure to UV radiation to reduce skin cancer risks. The USPSTF graded this recommendation a "C". The explanation provided pointed to a small net benefit and that clinicians should consider the patient's potential risk factors in determining whether counseling is appropriate.[37]

Dermatologist Workforce

The federal Health Resources and Services Administration (HRSA) identifies geographic areas, population groups, and health care facilities with a shortage of health professionals and designates them health professional shortage areas (HPSAs). HPSAs can be designated as geographic areas; areas with a specific group of people such as low-income populations, homeless populations, and migrant farmworker populations; or as a specific facility that serves a population or geographic area with a shortage of providers.[38]

There are three categories of HPSA: primary care, dental health, and mental health.[39] As of September 30, 2023, Florida had 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.[40]

HRSA does not identify shortages in physician specialty or sub-specialty care, including dermatology.

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[34] Under the Patient Protection and Affordable Care Act (PPACA), all non-grandfathered health plans in the non-group and small-group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While not specifying the benefits within the EHB, the PPACA provides 10 categories of benefits and services which must be covered and then required the Secretary of Health and Human Services to further define the EHB. Under the PPACA, preventive services with an "A" or "B" rating from the USPSTF must be covered by most private health insurance plans. *See* Issue Brief, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services,: *Access to Preventive Services Without Cost Sharing: Evidence from the Affordable Care Act, Issue Brief HP 2022-01 (January 11, 2022), Office of Health Policy, Assistant Secretary for Planning and Evaluation,* available at preventive-services-ib-2022.pdf (hhs.gov) (last viewed January 12, 2024).

[35] U.S. Preventive Services Task Force, *Skin Cancer Prevention: Behavioral Counseling (March 20, 2018)* available at Recommendation: Skin Cancer Prevention: Behavioral Counseling | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) (last viewed January 12, 2024).

[36] Id.

[37] U.S. Preventive Services Task Force, *Skin Cancer Prevention: Behavioral Counseling (March 20, 2018)* available at Recommendation: Skin Cancer Prevention: Behavioral Counseling | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) (last viewed January 12, 2024).

[38] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last viewed January 8, 2024).

[39] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last viewed January 8, 2024).

[40] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last viewed January 8, 2024). To generate the report, select "Designated HPSA Quarterly Summary."

A 2021 report for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association examined Florida's statewide and regional physician workforce and made projections on workforce changes to 2035.[41] Between 2019 and 2035, the report estimates the physician supply will increase by six percent overall and by three to four percent for primary care; however, demand for physician services will grow 27 percent.[42] Estimates of current supply deficits indicate Florida needs 1,977 additional physicians for primary care and 1,650 for non-primary care.

For dermatology specifically, the IHS Markit Report found a supply of 1,111 physicians and a projected demand rate of 1,044 physicians in 2035 leading to a supply-demand difference of 67 and an adequacy rating of 106 percent. This indicates Florida has a more than sufficient number of dermatologists for the projected demand.[43] The projected growth rate in the number of physicians in dermatology from 2019 to 2035 is 26 percent, which closely matches the growth rate for primary care physicians (27 percent) under what the report called the "status quo scenario."[44]

Also noted in the report was that Florida's current supply of dermatologists, which was cited as more than adequate at 135 percent adequacy, has a surplus of 293 physicians.[45] One possible reason cited was Florida's high rate of melanoma cases and reference to a study finding that nearly one in ten Floridians (9.2 percent) had been diagnosed with skin cancer.[46]

The IHS report did not address the distribution of dermatologists in Florida; it is likely that some areas of the state have sufficient dermatologists (or a surplus), while others have less access. The Department of Health publishes data on dermatologist distribution. The chart below shows the number of dermatologists per county in Florida.[47]

[41] IHS Markit, Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035: 2021 Update to Projections of Supply and Demand (December 2021), available at Florida-Physician-Workforce-Analysis.pdf (fha.org) (last viewed January 12, 2024).
[42] Id.
[43] Id.
[44] The "status quo" scenario assumes a 10 percent increase in newly trained physicians entering the workforce annually resulting in 3,191 FTEs (6 percent) physicians in the workforce in 2035, while also assuming the average physician would delay retirement by two years which added 1,543 FTE physicians in the 2035 workforce. *See* notation on Exhibit 13 of IHS Markit Report.
Id.
[46] Id.
[47] Florida Department of Health, Physician Workforce Annual Report (November 2023) available at 2023 Physician Workforce Annual Report (floridahealth.gov) (last viewed January 18, 2024).

Licensed Florida Dermatologists by County 2023 Physicians Workforce Annual Report				
COUNTY	**#**		**COUNTY**	**#**
Alachua	23		Leon	10
Baker	0		Levy	0
Bay	26		Liberty	0
Bradford	1		Madison	0
Brevard	79		Manatee	18
Broward	330		Marion	13
Calhoun	0		Martin	14
Charlotte	9		Miami-Dade	152
Citrus	6		Monroe	3
Clay	3		Nassau	1
Collier	38		Okaloosa	10
Columbia	1		Okeechobee	1
Desoto	0		Orange	42
Dixie	0		Osceola	5
Duval	43		Palm Beach	148
Escambia	14		Pasco	20
Flagler	2		Pinellas	72
Franklin	0		Polk	22
Gadsden	0		Putnam	0
Gilchirst	0		St. Johns	15
Glades	0		St. Lucie	5
Guif	1		Santa Rosa	3
Hamilton	1		Sarasota	46
Hardee	0		Seminole	23
Hendry	0		Sumter	8
Hernando	4		Suwannee	0
Highlands	4		Taylor	0
Hillsborough	78		Union	0
Holmes	0		Volusia	20
Indian River	9		Wakulla	0
Jackson	0		Walton	2
Jefferson	0		Washington	0
Lafayette	0		Out of State	21
Lake	18		No County	13
Lee	34			

State Employee Health Plan

For state employees who participate in the state employee benefit program, the Department of Management Services (DMS) through the Division of State Group Insurance (DSGI) under the authority of s. 110.123, F.S., administers the state group health insurance program (Program). The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[48] To administer the program, DSGI contracts with third party administrators for self-insured plans, a fully

[48] A section 125 cafeteria plan is a type of employer offered, flexible health insurance plan that provides employees a menu of pre-tax and taxable qualified benefits to choose from, but employees must be offered at least one taxable benefit such as cash, and one qualified benefit, such as a Health Savings Account.

insured HMO, and a pharmacy benefits manager for the state employees' self-insured prescription drug program, pursuant to s.110.12315, F.S.

The state employee health plan contracts currently cover dermatology visits and skin cancer screenings as a specialist office visit. Depending on the plan chosen by the employee, the appropriate out of pocket cost or costs then applies for the specialist office visit.[49]

Effect of Proposed Changes

CS/HB 241 requires health insurers and HMOs under contract with the DSGI to cover annual skin cancer screenings without payment towards a deductible or co-insurance, copayment, or any other cost sharing by the covered individual when conducted by a dermatologist licensed under chapters 458 or 459, a physician assistant licensed under chapters 458 or 459, or an advanced practice nurse practitioner licensed under chapter 464 who is licensed under the supervision of a dermatologist licensed under chapters 458 or 459, F.S. The payment for the screening is to be consistent with other payments for preventive screenings as defined by the American Medical Association Current Procedural Terminology code set.

The bill further prohibits an insurer or HMO contracted with DSGI from bundling a payment for the skin cancer screening with services performed with any other service or procedure, including an evaluation and management visit which is performed during the same office visit or a subsequent office visit. Under this provision, the insurer or HMO may not bundle payments to a provider which would include a patient's annual skin cancer screening service with the payments to that provider for any other service, even if conducted on another day.

When a benefit or service has a patient cost sharing requirement, such as a specialist office co-payment, that amount is deducted from the provider's reimbursement from the insurer or HMO as the amount becomes the responsibility of the provider to collect from the patient for full reimbursement. If there is no cost sharing for a service expected from the patient, then 100 percent of the reimbursement for the service is the responsibility of the insurer or HMO, depending on the contract terms between the health care provider and the insurer or HMO. The unbundling of visits provides assurances to the health care provider that 100 percent reimbursement for the skin care screening has been received from the insurer or the responsibility third party payor.

The DSGI has estimated the annual increase in costs associated with the addition of this benefit for the state group employee group population as $357,580.

The change contemplated in CS/HB 241 would be effective for contracts issued or renewed on or after January 1, 2025.

The bill will take effect on July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 110.12303, F.S.; coverage for annual skin cancer screenings.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[49] Department of Management Services, *Agency Bill Analysis – HB 241/SB 56 (January 12, 2024) (on file with the Select Committee on Health Innovation).*

2. Expenditures:

   For the state employee group health plan, the DSGI has estimated an annual increase of $357,580 for the impact of the no cost sharing liability in the coverage of annual skin cancer screenings.

Expenditures:	Based on an analysis by the state group insurance health plans' actuaries, the estimated Fiscal Impact is $357,580.00 annually to DSGI health insurance program, if there is no cost sharing liability for the coverage of annual skin cancer screenings. The fiscal impact reflects a combination of the effect of projected changes in health care utilization behavior of insured members and the removal of copayments for services.[50]

Health Plan	**Member count utilized for fiscal analysis by health plan**	**Per Member Per Month (PMPM)**	**Annual increase**
Self-Insured Plans			
United Health Care	56,000	$0.14	$39,000.00
Aetna	60,225	$0.07	$53,758.00
Florida Blue	151,290	$0.14	$256,000.00
Fully Insured Plans			
Capital Health Plan	54,073	$0.014	$8,822.00
Total			**$357,580.00**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Not Applicable.

2. Expenditures:

   Not Applicable.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The inclusion of coverage for skin cancer screenings without cost sharing restrictions may positively impact physicians who likely will see an increased demand for their services, as well as collateral and ancillary medical supports such as laboratories and diagnostic offices which will be called upon to process additional lab slips, biopsies, and scans.

D. FISCAL COMMENTS:

The bill also prohibits an insurer from bundling payments for skin cancer screenings performed under this bill with any other procedure. According to DSGI, State Group insurers do bundle payments currently based on the primary code, and there is no current CPT code for "skin cancer screenings." As a result, the insurers may have to manually review clinical records to input these changes and update several systems and processes. Plans may incur costs related to this administrative burden and for updates to claims processing systems.[51]

[50] Department of Management Services, *Email correspondence from Jake Holmgreen, Deputy Legislative Affairs Director (January 16, 2024)(on file with the Select Committee on Health Care Innovation).*
[51] Supra, note 49.

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 DSGI has sufficient rule-making authority under current law to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 16, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Limits application of the requirement for annual skin cancer screenings without cost sharing restrictions to the State Group Health Insurance Plan effective January 1, 2025.
- Removes provisions requiring health insurers and HMOs to provide coverage for annual skin cancer screenings without cost sharing restrictions.
- Adds physician assistants and advanced practice registered nurses practicing under the supervision of a dermatologist to conduct skin cancer screenings.
- Prohibits State Group Plan insurers and health plans from bundling a payment for a skin cancer screening with any other procedure or service which is performed during the same or a subsequent visit.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.

A bill to be entitled

An act relating to coverage for skin cancer screenings; amending s. 110.12303, F.S.; requiring the Department of Management Services to provide coverage and payment through state employee group health insurance contracts for annual skin cancer screenings performed by specified persons without imposing any cost-sharing requirement; specifying a requirement for and a restriction on payments for such screenings; providing an effective date.

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

Section 1. Subsection (5) is added to section 110.12303, Florida Statutes, to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—

(5)(a) Effective January 1, 2025, the department shall require all contracted state group health insurance plans and HMOs to provide coverage and payment, without imposing a deductible, copayment, coinsurance, or any other cost-sharing requirement on the covered individual, for annual skin cancer screenings performed by a dermatologist licensed under chapter 458 or chapter 459, or by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered

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

nurse licensed under chapter 464 who is under the supervision of a dermatologist licensed under chapter 458 or chapter 459. Payment for such screenings must be consistent with how the state group health insurance plan or HMO pays for other preventive screenings as defined by the American Medical Association's Current Procedural Terminology codes.

(b) A state group health insurance plan or HMO participating under this section may not bundle a payment for skin cancer screenings performed under this section with any other procedure or service, including, but not limited to, an evaluation and management visit which is performed during the same office visit or a subsequent office visit.

Section 2. This act shall take effect July 1, 2024.

HB 631

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 631 Aftercare Services Under Road-To-Independence Program
SPONSOR(S): Children, Families & Seniors Subcommittee, Tramont
TIED BILLS: **IDEN./SIM. BILLS:** SB 564

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	14 Y, 0 N	DesRochers	Brazzell
2) Health Care Appropriations Subcommittee	14 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee		DesRochers	Calamas

SUMMARY ANALYSIS

The Florida Department of Children and Families (DCF) contracts with Community-Based Care Lead Agencies (CBCs) to provide child protection and child welfare services to children and families in Florida. While the appropriate care of children is ultimately the responsibility of the state, DCF protects the best interests of children by achieving certain outcomes in conjunction with the CBCs. These outcomes include helping children receive appropriate services to meet their educational needs and to develop the capacity for independent living and competence as an adult.

Young adults who age out of the foster care system more frequently have challenges achieving self-sufficiency compared to young adults who never came to the attention of the foster care system.

Federal and state programs currently offer financial assistance to eligible young adults who desire the acquisition of skills, education, and necessary support to become self-sufficient and exit foster care. Aftercare services are intended to bridge gaps in an eligible young adult's progress towards self-sufficiency; eligibility is focused on individuals who have aged out of foster care at 18 and are younger than age 23. DCF or a CBC determines the specific Aftercare services provided to eligible young adults after an assessment.

HB 631 expands access to Aftercare services for young adults formerly in the child welfare system. Under the bill, any young adult who, having been placed by a court pursuant to dependency statutes, has lived in out-of-home care for at least 6 months after he or she turned 14 years of age will be eligible as long as the young adult is at least 18 years of age but not 23 years of age. Services may not duplicate certain other DCF independent living services the young adult receives.

The bill also authorizes DCF to distribute federal funds to all young adults deemed eligible by the federal funding source in the event of a state of emergency declared by the Governor or the President of the United States.

The bill has a significant, indeterminate, negative fiscal impact on DCF and no fiscal impact on local governments. See Fiscal Analysis.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Florida Department of Children and Families

The Florida Department of Children and Families (DCF) contracts with Community-Based Care Lead Agencies (CBCs) to provide child protection and child welfare services to children and families in Florida.[1] There are 18 lead agencies that each cover specific geographic areas within the 20 Judicial Circuits in Florida. Several lead agencies cover more than one geographic area, and areas may include one or more counties. DCF contracts with community-based care lead agencies (CBCs) for case management, out-of-home services, and related services. The outsourced provision of child welfare services is intended to increase local community ownership of service delivery and design. CBCs in turn contract with a number of subcontractors for case management and direct care services to children and their families.

While the appropriate care of children is ultimately the responsibility of the state, DCF protects the best interests of children by achieving certain outcomes in conjunction with the CBCs. These outcomes include helping children receive appropriate services to meet their educational needs and to develop the capacity for independent living and competence as an adult.[2]

Out-of-Home Care

When children cannot safely remain at home with parents, Florida's child welfare system finds safe out-of-home placements for children. Through December 2023, there were 19,334 children and young adults in out-of-home care in Florida.[3] After a placement assessment to determine the most appropriate out-of-home placement, a child may be placed in licensed care or with a relative or a non-related individual known to the child, termed "fictive kin". Licensed care includes licensed foster parents and group homes or other licensed residential setting.[4]

Transition to Adulthood

Young adults who age out of the foster care system more frequently have challenges achieving self-sufficiency compared to young adults who never came to the attention of the foster care system. Young adults who age out of the foster care system are less likely to earn a high school diploma or GED and more likely to have lower rates of college attendance.[5] They have more mental health problems, have a higher rate of involvement with the criminal justice system, and are more likely to have difficulty achieving financial independence.[6] These young adults also have a higher need for public assistance and are more likely to experience housing instability and homelessness.[7]

In federal fiscal year 2021, the federal Children's Bureau within the U.S. Department of Health & Human Services reported 46,694 teens and young adults entered foster care in the United States,[8] with

[1] S. 409.986(1)(a), F.S.
[2] S. 409.986(2), F.S.
[3] Office of Child and Family Well-Being, *Monthly Trends*, Florida Department of Children and Families, (last updated Jan. 10, 2024) https://www.myflfamilies.com/ocfw-dashboard (last visited Jan. 27, 2024).
[4] Ss. 39.4022(6), 39.523(2), F.S.
[5] Gypen, L., Vanderfaeillie, J., et al., "Outcomes of Children Who Grew Up in Foster Care: Systematic-Review", *Children and Youth Services Review*, vol. 76, pp. 74-83, http://dx.doi.org/10.1016/j.childyouth.2017.02.035 (last visited November 30, 2023).
[6] *Id*.
[7] *Id*.
[8] Children's Bureau, *The Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2021 data*, U.S. Department of Health and Human Services, p. 2, June 28, 2022, https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-29.pdf (last accessed Dec. 3, 2023).

2,167 teens and young adults entering Florida's foster care system.[9] The Children's Bureau also collects information and outcomes on youth and young adults currently or formerly in foster care who received independent living services supported by federal funds.[10] To this end, the Children's Bureau's National Youth in Transition Database (NYTD) representation tracks the independent living services each state provides to foster youth in care and assesses each state's performance in providing independent living and transition services.

DCF will establish its fifth NYTD report (Oct. 2022 – Sept. 2023) that surveys youth in Florida's foster care system beginning on their 17th birthday.[11] In the interim, the most recent Florida NYTD available on DCF's website is the 2018 report.[12] In the chart below, the 2018 Florida NYTD documented outcomes related to education, employment, housing, finances and transportation, health and well-being, and connections:[13]

Outcomes of Young Adults who Aged Out of Care	
Area	**Outcome**
Education	• 74% were enrolled in and attending high school, GED classes, post-high school vocational training, or college. • 12% experienced barriers that prevented them from continuing education. The top three reported barriers included the need to work full-time, not having transportation, and having academic difficulties.
Employment	• 15% were employed full-time (35 hours per week or more). • 26% were employed part-time. • 78% had a paid job over the last year. • 22% completed an apprenticeship, internship, or other on-the-job training, either paid or unpaid.
Housing	• The top three current living situations included living in their own apartment, house, or trailer; living with friends or a roommate; and living in a group care setting (including a group home or residential care facility). • 41% had to couch surf or move from house to house because they did not have a permanent place to stay. • 27% experienced some type of homelessness in the past year.[14]
Financial & Transportation	• 46% received public food assistance. • 10% received social security payments (Supplemental Security Income, Social Security Disability Insurance, or dependents' payments). • 83% had a reliable means of transportation to school/work. • 76% had an open bank account.

[9] Children's Bureau, *The Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2021 data: Florida* , U.S. Department of Health and Human Services, p. 1, June 28, 2022, https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-tar-fl-2021.pdf (last accessed Dec. 3, 2023).
[10] Children's Bureau, *Data and Statistics: National Youth in Transition Database*, U.S. Department of Health & Human Services, https://www.acf.hhs.gov/cb/data-research/data-and-statistics-nytd#FL_26606 (last visited Dec. 3, 2023).
[11] Florida Department of Children and Families, *Independent Living Services Annual Report*, Office of Child Welfare, Feb. 2023, p. 15 https://www.myflfamilies.com/sites/default/files/2023-07/Independent_Living_Services_Report_2022.pdf (last visited Dec. 4, 2023).
[12] Florida Department of Children and Families, *Annual Reports for Independent Living*, Child and Family Services, https://www.myflfamilies.com/services/child-family/independent-living/annual-reports-for-independent-living (last visited Dec. 4, 2023).
[13] Florida Department of Children and Families, *Florida National Youth in Transition Database, 2018 Survey Data Report*, https://www.myflfamilies.com/sites/default/files/2023-06/2018%20Florida%20NYTD%20Statewide%20Report%20Final.pdf (last visited Dec. 4, 2023).
[14] *Id*.

Health & Well-Being	• 85% were on Medicaid. • 18% had children. • 34% had not received medical care for a physical health problem, treatment for a mental health problem, or dental care in the past two years for some health problem needing to be addressed. • 24% were confined in a jail, prison, correctional facility, or juvenile detention facility within the past two years.
Connections	• 85% had at least one adult in their life, other than their case manager, to go to for advice or emotional support. • 67% had a close relationship with biological family members.

The Federal John H. Chafee Foster Care Program for Successful Transition to Adulthood

The John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee program) provides funding to support young adults in or formerly in foster care in their transition to adulthood. The program is funded through formula grants awarded to child welfare agencies in States (including the District of Columbia, Puerto Rico and the U.S. Virgin Islands) and participating Tribes. The program is funded at $143 million a year.[15]

Chafee funds are used to assist young adults in a wide variety of areas designed to support a successful transition to adulthood. Activities and programs include, but are not limited to, help with education, employment, financial management, housing, emotional support and assured connections to caring adults. Specific services and supports are determined by the child welfare agency, vary by State, locality and agency, and are often based on the individual needs of the young person. Many State or local agencies contract with private organizations to deliver services to young people.[16]

Eligibility for the program, as outlined in federal law, includes:

- Youth in foster care, ages 14 and older
- Young people in or formerly in foster care, ages 18 to 21, or 23 in some jurisdiction
- Youth who left foster care through adoption or guardianship at age 16 or older
- Youth "likely to age out of foster care" to receive assistance to participate in age appropriate and normative activities

States and Tribes may have additional requirements for eligibility.[17]

In 2022, the federal government allotted $7,175,951 in federal Chafee dollars to Florida for the purpose of independent living services.[18]

[15] Administration for Children and Families, *John H. Chafee Foster Care Program for Successful Transition to Adulthood*, U.S. Department of Health and Human Services, (last updated July 3, 2024) https://www.acf.hhs.gov/cb/grant-funding/john-h-chafee-foster-care-independence-program (last visited Jan. 26, 2024).
[16] *Id.*
[17] *Id.*
[18] Administration for Children and Families, *FY 2022 Allotment for Chafee Foster Care Program for Successful Transition to Adulthood Grants*, U.S. Department of Health and Human Services, Attachment A, p. 8 (Feb. 9, 2023) https://www.acf.hhs.gov/sites/default/files/documents/cb/pi2301.pdf (last visited Jan. 26, 2024).

Florida Programs for Older Youth and Young Adults

Florida uses the federal Chafee funding, along with other funding such as Title IV-E and state General Revenue, for programs and services for older youth in foster care and young adults formerly in foster care. Such programs include:

- Extended foster care.
- Road-to-Independence programs:
  - Postsecondary Supports and Services, and
  - Aftercare.
- DCF's Office of Continuing Care.

Extended foster care and the Road-to-Independence programs have different eligibility requirements and benefits.

Extended Foster Care

A young adult who is living in licensed care on his or her 18th birthday and who has not achieved permanency may choose to remain under court supervision and the care of DCF through extended foster care.[19] If the young adult chooses to remain in care beyond his or her 18th birthday, then the young adult's permanency goal becomes transitioning to independence.[20] To this end, a young adult who chooses extended foster care must participate in one of four self-sufficiency activities. These four self-sufficiency activities include:

1. Completing secondary education or a program leading to an equivalent credential;
2. Being enrolled in an institution that provides postsecondary or vocational education;
3. Participating in a program or activity designed to promote or eliminate barriers to employment; or
4. Being employed for at least 80 hours per month.

However, the child may be excused from the self-sufficiency activities if the child has a documented physical, intellectual, emotional, or a psychiatric condition that limits the child's full-time participation.[21]

In addition to one or more self-sufficiency activities, the young adult in extended foster care must independently reside in a supervised living environment that DCF or a CBC approved. In other words, the young adult must continue to receive supervision, case management, and supportive services from DCF or a CBC but live independently in an environment that offers developmentally appropriate freedom and responsibility to prepare the young adult for adulthood.[22] Meanwhile, the court maintains jurisdiction to ensure that DCF and CBCs provide services and coordinate with, and maintain oversight of, other agencies involved in implementing the young adult's case plan, individual education plan, and transition plan.[23]

A supervised living arrangement may include a licensed foster home, licensed group home, college dormitory, shared housing, apartment, or another housing arrangement approved by CBC that is acceptable to the young adult. A young adult may continue to reside with the same licensed foster family or group care provider with whom he or she was residing at the time he or she reached the age of 18 years.[24] Through December 2023, 785 young adults (18-22) were in out-of-home care in Florida.[25]

[19] S. 39.6251(1), F.S.
[20] S. 39.6251(3), F.S.
[21] S. 39.6251(2), F.S.
[22] S. 39.6251(4)(a), F.S.
[23] S. 39.6251(8), F.S.
[24] S. 39.6251(4)(a), F.S.
[25] *Supra*, FN 3.

A young adult ages out of extended foster care when he or she turns 21 (or 22 if the young adult has a disability), achieves permanency, or knowingly and voluntarily withdraws consent to participate in extended foster care – whichever comes first.[26]

Florida's Road-to-Independence Program

Current law offers financial assistance to eligible young adults who desire the acquisition of skills, education, and necessary support to become self-sufficient and exit foster care. Eligible young adults access financial assistance through postsecondary education services and support (PESS) or aftercare services.[27]

PESS

The PESS stipend helps eligible young adults seek higher education and self-sufficiency. A young adult becomes PESS eligible once eight criteria are met:

1. A former foster youth who is in one of three situations:
    a. Turned 18 years of age while in the legal custody of DCF,
    b. Adopted from foster care after the age of 16 after spending at least 6 months in licensed care within the 12 months immediately preceding the adoption, or
    c. Placed with a court-approved permanent guardian after the age of 16 after spending at least 6 months in licensed care within the 12 months immediately preceding the permanent guardianship.
2. Spent at least 6 months in licensed care before reaching their 18th birthday.
3. Earned a standard high school diploma or its equivalent.
4. Admitted for enrollment as a full-time student[28] at an eligible Florida Bright Futures postsecondary educational institution.
5. Reached the age of 18 but is not yet 23 years of age.
6. Applied for other grants and scholarships that the eligible young adult qualifies for.
7. Submitted a complete and error-proof Free Application for Federal Student Aid.
8. Signed an agreement to allow DCF and the CBC lead agency access to school records.[29]

After establishing eligibility, DCF determines the PESS stipend amount. Generally, the PESS stipend amount is $1,720/month. However, if the young adult remains in foster care while attending a postsecondary school and resides in a licensed foster home, the monthly PESS stipend amount is the established room and board rate for foster parents. If the young adult remains in foster care while attending a postsecondary school and resides in a licensed group home, the monthly PESS stipend amount is negotiated between the CBC lead agency and the licensed group home provider.[30]

Before an eligible young adult receives the PESS stipend, DCF or its contracted agency must assess the young adult's financial literacy and existing competencies necessary for successful independent living and the completion of postsecondary education.[31] Eligible young adults receive financial assistance during the months when they are enrolled in a postsecondary education institution.[32]

Aftercare Services

[26] S. 39.6251(5), F.S.
[27] S. 409.1451(1)(c), F.S.
[28] Students may enroll part-time if they have a recognized disability or if they secure approval from their academic advisor relating to a challenge or circumstance preventing full-time enrollment. Otherwise, full-time enrollment requires 9 credit hours or the vocational school equivalent.
[29] S. 409.1451(2)(a), F.S.
[30] S. 409.1451(2)(b), F.S.
[31] S. 409.1451(2)(d), F.S.
[32] S. 409.1451(2)(b), F.S.

Aftercare services are intended to bridge gaps in an eligible young adult's progress towards self-sufficiency. A young adult establishes eligibility for aftercare services if the young adult meets three four criteria:

1. Reached the age of 18 while in licensed foster care
2. Is currently at least 18 years old, but is not yet 23 years of age.
3. Is not in Extended Foster Care pursuant to s. 39.6251, F.S.
4. Temporarily not receiving a PESS stipend.[33]

Aftercare funding is also available to current PESS recipients under some emergency situations.[34]

The requirement that a young adult have reached the age of 18 in licensed care is in DCF rule.[35] This rule is consistent with the 2012 statutes, which required Aftercare recipients to have aged out of foster care. A 2013 revision to the Road-to-Independence program statute was included in a bill focusing on services for young adults who aged out of foster care or were adopted in their later teens; this revision removed the requirement that a young adult must have aged out of foster care to receive Aftercare services, though the intent language of the section refers to both individuals who have spent time in foster care and those who have aged out of care.[36]

Thus under DCF rule, an individual must have been living in a licensed foster home or other licensed residential setting at age 18 to receive Aftercare funding, or receive PESS and have a qualifying emergency situation. This excludes individuals who had spent time in the dependency system but reached permanency such that they did not age out of care (meaning they were not in a licensed foster home or other licensed residential setting when they turned age 18). For example, young adults who were adopted as older teens but no longer are being supported by their adoptive parents are ineligible for Aftercare services; neither are young adults who achieve reunification with a parent as an older teen.

Aftercare services include, but are not limited to, the following:

1. Mentoring and tutoring.
2. Mental health services and substance abuse counseling.
3. Life skills classes, including credit management and preventive health activities.
4. Parenting classes.
5. Job and career skills training.
6. Counselor consultations.
7. Temporary financial assistance for necessities.
8. Temporary financial assistance for emergencies like automobile repairs or large medical expenses.
9. Financial literary skills training.[37]

DCF or a CBC lead agency determines the specific Aftercare services provided to eligible young adults after an assessment.[38] The resulting aftercare services plan is reassessed every 90 days.[39] Subject to available funding, Aftercare services are available to PESS stipend grantees who experience an emergency situation and whose resources are insufficient to meet the emergency situation.[40]

[33] S. 409.1451(3)(a), F.S.; R. 65C-42.003(1), F.A.C.
[34] S. 409.1451(3)(a)2., F.S.
[35] R. 65C-42.003(1), F.A.C.
[36] Ch. 13-178, L.O.F.
[37] S. 409.1451(3)(b), F.S.
[38] S. 409.1451(3)(b), F.S.; R. 65C-42.003(6), F.A.C.
[39] R. 65C-42.003(8), F.A.C.
[40] S. 409.1451(3)(a), F.S.

In total, DCF reports in the table below that Florida spent the following amounts on Aftercare services for the past three fiscal years.[41]

Fiscal Year	Eligible Population	Actual Participants	Participation Rate	Per Youth Expenditure	Total Expenditures
2020-2021	3,119	316	10%	$2,625	$829,726
2021-2022	3,045	371	12%	$3,841	$1,425,261
2022- 2023	3,034	421	14%	$4,385	$1,846,401

DCF reports that Florida experienced a 13% increase in the total number of young adults receiving independent living services for state fiscal year (SFY) 2022-2023 compared to SFY 2021-2022.

The table below itemizes the number of young adults served in each Independent Living program by each CBC Lead Agency during the past two state fiscal years (SFYs):[42]

Lead Agency	2021-2022			2022-2023		
	Aftercare	EFC	PESS	Aftercare	EFC	PESS
Brevard Family Partnership	28	33	14	27	104	11
ChildNet Inc	22	166	112	24	166	112
ChildNet Palm Beach	14	126	68	11	118	62
Children's Network of SW Florida	8	41	58	8	65	34
Citrus Health Network	39	229	198	48	269	186
Communities Connected for Kids	16	28	25	11	28	26
Community Partnership for Children	8	49	37	16	76	47
Family Support Services Suncoast	42	104	62	49	105	55
Children's Network Hillsborough	57	87	40	57	146	60
Embrace Families	32	117	58	38	145	57
Families First Network	12	98	28	11	100	19
St Johns County Commission	5	12	8	0	12	8
Family Support Services	36	97	33	23	107	31
Heartland for Children	32	79	23	37	91	29
Kids Central Inc	39	28	27	54	54	39
Kids First of Florida Inc	0	16	10	0	27	13
NWF Health Network-East	16	55	35	19	67	27
Partnership for Strong Families	10	16	12	6	16	5
Safe Children Coalition	17	37	16	29	37	16
Statewide	**433**	**1,418**	**864**	**467**	**1,733**	**857**

Office of Continuing Care

The Office of Continuing Care at DCF helps individuals who have aged out of the child welfare system, until age 26. The office provides ongoing support and care coordination needed for young adults to achieve self-sufficiency. Duties of the office include, but are not limited to:

- Informing young adults who age out of the foster care system of the purpose of the office, the types of support the office provides, and how to contact the office.
- Serving as a direct contact to the young adult in order to provide information on how to access services to support the young adult's self-sufficiency, including but not limited to, food assistance, behavioral health services, housing, Medicaid, and educational services.

[41] Florida Department of Children and Families, *Agency Analysis for 2024 House Bill 631*, p. 2 (2024).
[42] Department of Children and Families, *Department of Children and Families Response to the Independent Living Services Advisory Council 2023 Annual Report*, p. 6 (Dec. 31, 2023) https://www.myflfamilies.com/services/child-family/lmr (last visited Jan. 4, 2023).

- Assisting in accessing services and supports for the young adult to attain self-sufficiency, including, but not limited to, completing documentation required to apply for services.
- Collaborating with CBC's to identify local resources that can provide support to young adults served by the office.
- Developing and administering the Step into Success Workforce Education and Internship Pilot Program for foster youth and former foster youth as required under s. 409.1455.[43]

Effect of the Bill

Aftercare

HB 631 expands access to Aftercare services to a broader population of young adults who were involved in Florida's child welfare system. Under the bill, the following individuals are eligible:

- were placed by a court under Florida's dependency statutes,
- lived in out-of-home care (including licensed placements and placements with family members or fictive kin) for at least 6 months after turning 14 years of age, and
- are at least 18 years of age but not 23 years of age.

Therefore, the bill allows more young adults who were formerly in care, regardless of the out-of-home placement type they were in or whether they achieved permanency before age 18, to receive Aftercare services.

While the bill allows a young adult to receive Aftercare services even if the young adult simultaneously benefits from PESS or is in EFC, the bill prohibits duplicative services and supports.

Distribution of Funding in Emergencies

In the event of a state of emergency declared by the Governor or the President of the United States, the bill allows DCF to distribute federal funds to all young adults deemed eligible by the funding source, even if these eligibility standards are different than those of the PESS program or Aftercare. This means that young adults who would not meet the eligibility criteria of those programs could receive federal funding if DCF distributes funding to those who are not otherwise eligible.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amending s. 409.1451, F.S., relating to the road-to-independence program.
Section 2: Providing an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill expands the eligibility for Aftercare services to former foster youth, resulting in an anticipated cost increase to the Independent Living Program. Based upon data from the Florida Safe Families Network and various assumptions regarding participation rates, the department

[43] S. 414.56, F.S.

estimates a cost of up to $6,446,995 to serve the additional population.[44] An alternative assumption based upon a differing participation rate in the department's Legislative Budget Request (LBR) for an increase to the Independent Living Program suggests a lower cost estimate of $3,428,700 to cover the expanded, eligible Aftercare services population.[45]

The House proposed General Appropriations Act for FY 2024-25 includes $8,110,140 to fund the expanded eligibility of Independent Living programs contemplated in HB 1083, which is contingent upon the passage of that bill. This includes the anticipated cost of $3,428,700 for Aftercare services. HB 1083 has been reported favorably by the Children, Families, and Seniors Subcommittee and will next be considered by the Appropriations Committee.[46]

Aftercare services are subject to available funding. Certain services can be curtailed should the appropriation in HB 1083 be insufficient to cover the entire eligible population. Furthermore, to the extent that the initial assumptions of eligible populations and participation rates do not comport with the actual, observed number of participants and rates during FY 2024-25, the department can submit an LBR for FY 2025-26 for the additional need.

It is unknown whether DCF will spend federal funds during an official state of emergency.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some individuals who do not currently receive Aftercare services may be able to receive them in the future.

D. FISCAL COMMENTS:

None.

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:

DCF has sufficient rulemaking authority to carry out the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

[44] *Supra*, FN 41.
[45] Florida Department of Children and Families, *Agency Legislative Budget Request for Fiscal Year 2024-2025, Exhibit D-3A: Expenditures by Issue and Appropriation Category*, (Sept. 14, 2023) http://floridafiscalportal.state.fl.us/Document.aspx?ID=26122&DocType=PDF (last visited Feb. 12, 2024).
[46] HB 5001, House General Appropriations Act, Specific Appropriation 330.

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to aftercare services under the Road-to-Independence Program; amending s. 409.1451, F.S.; revising the eligibility requirements for a young adult to receive aftercare services; limiting the aftercare services available to young adults under certain circumstances; authorizing the Department of Children and Families to distribute federal funds to young adults, regardless of their eligibility, under certain circumstances; providing an effective date.

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

Section 1. Subsection (11) of section 409.1451, Florida Statutes, is renumbered as subsection (12), paragraph (a) of subsection (3) is amended, and a new subsection (11) is added to that section, to read:

409.1451 The Road-to-Independence Program.—

(3) AFTERCARE SERVICES.—

(a)~~1.~~ Aftercare services are available to a young adult who has reached 18 years of age but is not yet 23 years of age who, having been placed by a court pursuant to chapter 39, has lived in out-of-home care for at least 6 months after he or she turned 14 years of age. A young adult who receives services and support under subsection (2) or s. 39.6251 is only eligible for

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

aftercare services that are not otherwise covered or provided under subsection (2) or s. 39.6251. ~~and is:~~

~~a. Not in foster care.~~

~~b. Temporarily not receiving financial assistance under subsection (2) to pursue postsecondary education.~~

~~2. Subject to available funding, aftercare services as specified in subparagraph (b)8. are also available to a young adult who is between the ages of 18 and 22, is receiving financial assistance under subsection (2), is experiencing an emergency situation, and whose resources are insufficient to meet the emergency situation. Such assistance shall be in addition to any amount specified in paragraph (2)(b).~~

(11) Notwithstanding the eligibility criteria or availability of services and support under subsections (2) and (3), the department may distribute federal funds to all young adults deemed eligible by the funding source in the event of a state of emergency declared by executive order or proclamation of the Governor pursuant to chapter 252 or the President of the United States.

Section 2. This act shall take effect July 1, 2024.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 883 Short-acting Bronchodilator Use in Public and Private Schools
SPONSOR(S): Choice & Innovation Subcommittee, Koster
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 962

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Choice & Innovation Subcommittee	16 Y, 0 N, As CS	Dixon	Sleap
2) PreK-12 Appropriations Subcommittee	11 Y, 0 N	Potvin	Potvin
3) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

To provide access to life-saving interventions during a student's respiratory distress at a public or private school, the bill authorizes a public or private school to acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor or to enter into an arrangement with a wholesale distributor or manufacturer, for short-acting bronchodilators and components at fair-market, free, or reduced prices. The bill specifies the requirements for storing and maintaining the stock supply of short-acting bronchodilators and components.

The bill authorizes specified health care practitioners to prescribe short-acting bronchodilators and components in the name of a public school or private school. Additionally, the bill authorizes a licensed pharmacist to dispense short-acting bronchodilators and components to a prescription issued in the name of a public or private school.

Under the bill, a public or private school may also accept short-acting bronchodilators and components as a donation or transfer if the items meet the U.S. Food and Drug Administration regulations and are in a new, unexpired, manufactured-sealed condition.

The bill outlines criteria for individuals authorized to administer short-acting bronchodilators and components to students at public and private schools and requires schools to inform parents of the school's adopted protocol and obtain parental permission before administering short-acting bronchodilators to a student in respiratory distress emergencies.

The bill provides that school districts and private schools and their employees and agents are not liable for any injury arising from the use or non-use of a short-acting bronchodilator or components administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is experiencing a respiratory distress emergency. The bill also provides exceptions for liability.

Additionally, the bill provides immunity from civil liability to authorized healthcare practitioners who prescribe, or dispensing pharmacists who fill, a prescription for a short-acting bronchodilator and components for use by a public or private school for any act or omission to act related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

The bill has no fiscal impact on state government and may have an insignificant, indeterminate, negative fiscal impact on school districts. *See* Fiscal Analysis.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Management of Childhood Asthma in Schools

Asthma is a chronic condition that involves inflammation of the airways. Individuals with asthma experience hyperresponsive airways, meaning their reactions to triggers such as colds, cigarette smoke, and exercise are faster and more intense than those with normal airways. This heightened reactivity leads to inflammation of the airway lining, tightening of surrounding muscles, airway narrowing, and increased production of mucus cells. These reactions reduce the airflow into the lungs and make breathing more challenging.[1]

In Florida, approximately 1 in 8 adults and 1 in 9 children have asthma.[2] Nationally, asthma stands as one of the most common chronic childhood diseases, impacting the daily lives of millions of American children.[3] As children with asthma attend school, their safety and the management of their condition becomes the shared responsibility of the family, their healthcare providers, and school personnel.[4]

While most schools are very cognizant of the seriousness of asthma, the distance from the classroom or playing field to the school health room can be perilously far for a child struggling to breathe.[5] As approximately 10 percent of school children have asthma and spend a significant amount of time at school, having access to a rescue inhaler is important.[6] Rescue inhalers, known as short-acting bronchodilators, are used for sudden, acute asthma symptoms and includes beta 2-agonists, which quickly open airways to stop asthma symptoms. Referred to as "reliever" or "rescue" medicines, they are the most effective for treating sudden, severe, or new asthma symptoms, working within 15 to 20 minutes and lasting for four to six hours.[7]

According to the American Lung Association, despite all 50 states and the District of Columbia having laws allowing students to carry and use asthma inhalers at school, it is still crucial for schools to move fast to save the life of a child during asthma emergencies. Situations may arise that can keep a child from getting the medications they need in a timely manner, such as forgetting an inhaler at home or facing financial constraints preventing the family from affording a second inhaler to keep at school.[8]

Given the unpredictable and potentially life-threatening nature of asthma exacerbations in children, timely access to rescue inhalers becomes a matter of life-saving significance. Addressing these concerns, in a 2021 policy statement on ensuring access to albuterol in schools, the American Thoracic

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[1] Florida Department of Health, *What is Asthma?* Available at https://www.floridahealth.gov/diseases-and-conditions/asthma/what-is-asthma.html (last visited February 5, 2024).
[2] *Id*.
[3] Asthma and Allergy Foundation of America, *Childhood Asthma*. Available at https://asthmaandallergies.org/asthma-allergies/childhood-asthma/ (last visited February 5, 2024).
[4] American Lung Association, *Improving Access to Asthma Medications in Schools* (2014). Available at https://www.lung.org/getmedia/872c9b6a-5379-4321-8913-102d53182e29/improving-access-to-asthma.pdf.pdf (last visited February 5, 2024).
[5] *Id*.
[6] American Academy of Allergy, *Asthma & Immunology, School stock inhaler program* (2021). Available at https://www.aaaai.org/tools-for-the-public/latest-research-summaries/the-journal-of-allergy-and-clinical-immunology/2021/school-inhaler (last visited February 5, 2024).
[7] Cleveland Clinic, *Bronchodilator*. Available at https://my.clevelandclinic.org/health/treatments/17575-bronchodilator (last visited February 5, 2024). The inhaled forms of short-acting beta 2-agonists medications include Albuterol, Levalbuterol, or a combination of albuterol and ipratropium bromide.
[8] American Lung Association, *Why Schools Should Stock Asthma Inhalers* (2023). Available at https://www.lung.org/blog/why-schools-should-stock-inhalers (last visited February 5, 2024).

Society and others,[9] stated that for children with asthma, access to quick-relief medications is critical to minimizing morbidity and mortality. The policy statement included an approach a state legislature could take to ensure access at school through stock albuterol policies whereby a school maintains a supply of stock albuterol that can be used by any student who experiences respiratory distress. The statement concluded that stock albuterol in schools is a safe, practical, and potentially life-saving option for children with asthma, whether asthma is diagnosed or undiagnosed, who lack access to their personal quick-relief medication.[10]

School Stock Albuterol Policies-Other States Efforts

Several states[11] have passed legislation and guidelines addressing asthma management in schools. While many state policies allow asthmatic students to carry an inhaler with them at school, some states have implemented policies which allow schools to stock quick-relief medications to respond to a student in a respiratory distress emergency.

For example, Virginia law requires each local school board to adopt and implement policies for the possession and administration of stock albuterol inhalers and valved holding chambers in every public school in the local school division.[12] Authorized personnel, such as a school nurse or employee of the school board, are responsible for administering the albuterol. In 2023, the Virginia Legislature expanded on those who could administer the albuterol inhalers to include authorized licensed athletic trainers under contract with a local school division.[13]

In 2022, the Arizona Legislature authorized school districts and charter schools to accept monetary donations or apply for grants to purchase inhalers and spacers or holding chambers. Alternatively, the school districts and charter schools may directly accept donations of these items from the product manufacturer.[14]

In Illinois, public and nonpublic schools are authorized to maintain a supply of asthma medication in any secure location that is accessible before, during, or after school where a person is most at risk.[15] Authorized personnel, such as school nurse or trained personnel, may administer the asthma medication to any person that the individual believed in good faith was in respiratory distress.

School Health Services in Florida

School health services are an important component of the public health system and help assure that Florida's students are healthy and ready to learn. School health services are intended to minimize health barriers to learning for public school students in grades prekindergarten through twelve in all 67 Florida counties.[16]

Asthma

[9] The policy statement was a joint effort made by the American Thoracic Society (ATS), The Allergy and Asthma Network Mothers of Asthmatics (AANMA), American Lung Associations (ALA), and the National Association of School Nurses (NASN).
[10] Anna Volerman, et al., *Ensuring Access to Albuterol in Schools: From Policy to Implementation*. An official ATS/AANMA/ALA/NASN Policy Statement, 204 American Journal of Respiratory and Critical Care Medicine 5 (2021). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8491259/pdf/rccm.202106-1550ST.pdf (last visited February 5, 2024).
[11] Examples of states that passed legislation and guidelines addressing asthma management in schools include Arkansas, ARK. CODE. § 6-18-707(d)-(h) (2019), California, CAL. CIVIL CODE § 49414.7 (2023), 105., Indiana, IND. CODE § 16-41-43-1, 16-41-43-3.5, 20-34-4.5-0.2, and 20-34-4.5-0.6 (2017), Iowa, IOWA CODE § 280.16 (2022), Montana, MO. REV. STAT. § 167.635 (2012), New Hampshire, N.H. REV. STAT. § 200:53 (2016), New Mexico, N.M. REV. STAT. ANN. § 24-31-1 (2018), Ohio, OHIO REV. CODE. ANN. § 3313.7113 (2023), Oklahoma, OKLA. STAT. tit. 70, §70-1-116.3 (2020), Texas, TEX. General-LAW MUNICIPALITY CODE ANN. § 38.001 (2007), Utah, UTAH CODE ANN. § 26-41-101 to 107 (2020).
[12] VA CODE.ANN. § 22.1-274.2, Virginia Law, *Code of Virginia*, § 22.1-274.2. Available at https://law.lis.virginia.gov/vacode/22.1-274.2/ (last visited February 11, 2024).
[13] VA CODE. ANN. § 8.01-225 (2023)
[14] ARIZ. REV. STAT. § 15-158 and § 22.1-274.2 (2022)
[15] Ill. COMP. STAT. 5/22-30 and 27A-5 (2017), *see also* Illinois Public Act, *SB3015 Enrolled*. Available at https://www.ilga.gov/legislation/publicacts/100/PDF/100-0726.pdf (last visited February 11, 2024).
[16] Florida Department of Education, *School Health Services*. Available at https://www.fldoe.org/schools/k-12-public-schools/sss/sch-health-serv.stml (last visited February 11, 2024). Service are provided in accordance with a local school health services plan under s. 381.0056(4)(a), F.S.

In accordance with Florida law, asthmatic students attending public school may carry a metered dose inhaler with them while in school, provided they have obtained approval from both their parent and physician. The school principal must be provided a copy of the parent's and physician's approval.[17] Current law does not expressly authorize an asthmatic student attending a private school to carry a metered dose inhaler with them while at school.

Epinephrine Use and Supply

Florida law also addresses the use of epinephrine auto-injectors for public and private K-12 students, at risk of life-threatening allergic reactions, known as anaphylaxis.

A public school student may carry and self-administer an epinephrine auto-injector and self-administer epinephrine by auto-injector while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities if the school has been provided with parental and physician authorization.[18] For each public school student authorized to carry an epinephrine auto-injector, the school nurse must develop an annual child-specific action plan for an anticipated health emergency in the school setting.[19]

Additionally, both K-12 public and private schools in Florida may purchase and maintain a supply of epinephrine auto-injectors in a secure, locked location on school premises for use if a student has an anaphylactic reaction.[20] A participating school district or private school is required to adopt a protocol developed by a licensed physician for administration of the epinephrine by school personnel.[21] The epinephrine auto-injectors may be administered by school personnel or self-administered by the student.[22]

K-12 public and private schools, their employees, agents, and physicians who provide the standing protocol are exempted from liability for any injury arising from the use of an epinephrine auto-injector if the epinephrine auto-injector is administered by trained school personnel who follows the protocol and reasonably believes that the student is having an anaphylactic reaction.[23] Florida law provides that the liability protections apply:[24]

- even if the student's parent has not been provided notice or has not signed a statement acknowledging that the school district is not liable; and
- regardless of whether authorization has been given by the student's parent or the student's physician.

However, the liability protections do not apply if the trained school personnel's action is willful and wanton.[25]

Effect of Proposed Changes

CS/HB 883 authorizes public and private schools to acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor[26]or to enter into an arrangement with a wholesale distributor or manufacturer,[27] for short-acting bronchodilators and components at fair-market,

[17] S. 1002.20(3)(h), F.S.
[18] S. 1002.20(3)(i)1., F.S.; *see also* rule 6A-6.0251, F.A.C.
[19] Rule 6A-6.0251, F.A.C.; *see also* rule 64F-6.004, F.A.C.
[20] Ss. 1002.20(3)(i)2., F.S. and 1002.42(17)(a), F.S.
[21] *Id*.
[22] *Id*.
[23] Ss. 1002.20(3)(i)3., F.S. and 1002.42(17)(b), F.S.
[24] *Id*.
[25] *Id*.
[26] S. 499.003(49), F.S. Wholesale distributor means a person, other than a manufacturer, a manufacturer's co-licensed partner, a third-party logistics provider, or a repackager, who is engaged in wholesale distribution.
[27] S. 499.003(29), F.S. Manufacturer means a person who holds a New Drug Application, an Abbreviated New Drug Application, a Biologics License Application, or a New Animal Drug Application approved under the federal act or license issued under s. 351 of the Public Health Ser vice Act, 42 U.S.C. s. 262, for such drug or biologics, or if such drug or biologics are not the subject of an approved

free, or reduced prices, in order to provide access to provide access to life-saving interventions during respiratory distress for children in school.

The bill authorizes specified health care practitioners to prescribe short-acting bronchodilators and components in the name of a public school or private school. Additionally, the bill authorizes a licensed pharmacist to dispense short-acting bronchodilators and components to a prescription issued in the name of a public or private school.

Under the bill, a public or private school may also accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

The bill requires that a school which has elected to stock a supply of short-acting bronchodilators and components must maintain the supply in a secure location on the school's premises. The participating school district or private school must adopt a protocol developed by a licensed physician for administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator and components. A school's supply of short-acting bronchodilators and components may be provided to trained school personnel members or students who have been authorized to self-administer such devices.

Under the bill the school district, public school, or private school, must provide written notice to the parent of each student enrolled in the school district, public school, or private school, of the school's adopted protocol and must receive prior permission from a student's parent to administer a short-acting bronchodilator or components in a respiratory distress emergency.

The bill specifies that school nurse or trained school personnel at a participating public or private school must only administer short-acting bronchodilators and components to students if they have successfully completed training and believe in good faith that the student is experiencing severe respiratory distress.

The bill provides that a school district and its employees and agents, as well as a private school and its employees and agents, acting in good faith are not liable for any injury arising from the use or non-use of a short-acting bronchodilator or components administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:

- Unless the trained school personnel's action is willful and wanton.
- Notwithstanding that the parents of the student to whom the short-acting bronchodilator is administered have not been provided notice or have not signed a statement acknowledging that the school district is not liable.
- Regardless of whether authorization has been given by the student's parents or by the student's physician, physician assistant, or advanced practice registered nurse.

The bill provides that any authorized healthcare practitioner who prescribes, or a dispensing pharmacist who fills, a prescription for a short-acting bronchodilator and components for use by a public or private school is immune from civil liability for any act or omission to act related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

The bill updates the terminology for the type of device an asthmatic public school student may carry from a metered-dose inhaler to a short-acting bronchodilator and component and authorizes an asthmatic private school student, similar to a public school student, to carry a short-acting bronchodilator and components while in school. The private school student's parent and physician must provide their approval to the private school's principal.

application or license, the person who manufactured the drug or biologics, a co-licensed partner or affiliates, and those manufacturing devices or cosmetics.

The bill defines the following terms:

- "Administer" to mean to give or to directly apply a short-acting bronchodilator or components to a student.
- "Asthma" to mean a chronic lung disease that inflames and narrows the airways, which can manifest as wheezing, chest tightness, shortness of breath, and coughing.
- "Authorized health care practitioner" to mean a physician, a physician assistant or a registered nurse, each licensed as defined under the law.
- "Components" to mean devices used as part of clinically recommended use of short-acting bronchodilators, which may include spacers, valved holding chambers, or nebulizers.
- "Respiratory distress" to refer to an individual experiencing difficulty breathing, which can be caused by a multitude of medical factors, including chronic diseases such as asthma.
- "Short-acting bronchodilator" to mean a beta-2 agonist, such as albuterol, used for the quick relief of asthma symptoms and recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. These bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or by a pressured metered-dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a short-acting bronchodilator recommended in the Guidelines for the Treatment of Asthma.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 2: Amends s. 1002.42, F.S., relating to private schools.
Section 3: Provides an effective date of July 1, 2024

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Schools that choose to act under the authority granted by the bill may incur costs associated with implementing the provisions of the bill. Schools that choose to exercise this authority may incur costs related to acquiring and storing a supply of short-acting bronchodilators and components, providing written notice to parents, and training personnel to administer the bronchodilators and their components.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 18, 2024, the Choice & Innovation Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment authorizes a private school, similar to a public school, to accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

The analysis is drafted to the committee substitute adopted by the Choice & Innovation Subcommittee.

A bill to be entitled

An act relating to short-acting bronchodilator use in public and private schools; amending ss. 1002.20 and 1002.42, F.S.; providing definitions; authorizing certain public and private school students to carry a short-acting bronchodilator and components; providing for public and private schools to receive prescribed short-acting bronchodilators and components in the school's name; authorizing public and private schools to acquire and stock a supply of short-acting bronchodilators and components through specified means; providing for the adoption of specified protocols relating to such short-acting bronchodilators and components; providing school district, public and private school, and parental requirements for the administration of such short-acting bronchodilators and components; providing construction; providing an effective date.

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

Section 1. Paragraph (h) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information

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

regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(h) Short-acting bronchodilator ~~Inhaler~~ use.—

1. As used in this paragraph, the term:

a. "Administer" means to give or directly apply a short-acting bronchodilator or components to a student.

b. "Asthma" means a chronic lung disease that inflames and narrows the airways, which can manifest as wheezing, chest tightness, shortness of breath, and coughing.

c. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or a registered nurse licensed under chapter 464.

d. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, which may include spacers, valved holding chambers, or nebulizers.

e. "Respiratory distress" refers to an individual experiencing difficulty breathing, which can be caused by a multitude of medical factors, including chronic diseases such as asthma.

f. "Short-acting bronchodilator" means a beta-2 agonist, such as albuterol, used for the quick relief of asthma symptoms

and recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. These bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or by a pressured metered-dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a short-acting bronchodilator recommended in the Guidelines for the Treatment of Asthma.

2. Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator and components ~~metered dose inhaler~~ on their person while in school. The school principal shall be provided a copy of the parent's and physician's approval.

3. An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a public school for use in accordance with this section and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a public school for use in accordance with this section.

4. A public school may acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as

defined in s. 499.003 for short-acting bronchodilators and components at fair-market, free, or reduced prices pursuant to a prescription issued in accordance with this section. The short-acting bronchodilators and components must be maintained in a secure location on a school's premises. The participating school district shall adopt a protocol developed by a licensed physician for administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator and components. The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator and components.

5. A public school may accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

6. A school nurse or trained school personnel shall only administer short-acting bronchodilators and components to students if they have successfully completed training and believe in good faith that the student is experiencing severe respiratory distress, regardless of whether the student has a prescription for a short-acting bronchodilator and components or has previously been diagnosed with asthma.

7. The school district or school shall provide written notice to the parent of each student enrolled in the school district or school of the school's adopted protocol and must receive prior permission from a student's parent to administer a short-acting bronchodilator or components in a respiratory distress emergency.

8. A school district and its employees and agents who act in good faith are not liable for any injury arising from the use or non-use of a short-acting bronchodilator or components administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:

a. Unless the trained school personnel's action is willful and wanton.

b. Notwithstanding that the parents of the student to whom the short-acting bronchodilator is administered have not been provided notice or have not signed a statement acknowledging that the school district is not liable.

c. Regardless of whether authorization has been given by the student's parents or by the student's physician, physician assistant, or advanced practice registered nurse.

9. Any authorized healthcare practitioner who prescribes, or a dispensing pharmacist who fills, a prescription for a short-acting bronchodilator and components for use by a school is immune from civil liability for any act or omission to act

related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

Section 2. Subsection (18) of section 1002.42, Florida Statutes, is renumbered as subsection (19) and subsection (18) is added to that section, to read:

1002.42 Private schools.—

(18) SHORT-ACTING BRONCHODILATOR USE.—

(a) As used in this paragraph, the term:

1. "Administer" means to give or directly apply a short-acting bronchodilator or components to a student.

2. "Asthma" means a chronic lung disease that inflames and narrows the airways, which can manifest as wheezing, chest tightness, shortness of breath, and coughing.

3. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or a registered nurse licensed under chapter 464.

4. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, which may include spacers, valved holding chambers, or nebulizers.

5. "Respiratory distress" refers to an individual experiencing difficulty breathing, which can be caused by a multitude of medical factors, including chronic diseases such as asthma.

6. "Short-acting bronchodilator" means a beta-2 agonist, such as albuterol, used for the quick relief of asthma symptoms and recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. These bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or by a pressured metered-dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a short-acting bronchodilator recommended in the Guidelines for the Treatment of Asthma.

(b) Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator and components on their person while in school. The school principal shall be provided a copy of the parent's and physician's approval.

(c) An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a private school for use in accordance with this section, and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a private school for use in accordance with this section.

(d) A private school may acquire and stock a supply of short-acting bronchodilators and components from a wholesale

distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as defined in s. 499.003 for short-acting bronchodilators and components at fair-market, free, or reduced prices pursuant to a prescription issued in accordance with this section. The short-acting bronchodilators and components must be maintained in a secure location on the school premises. The participating school shall adopt a protocol developed by a licensed physician for the administration of a short-acting bronchodilator or components by school personnel who are trained to recognize symptoms of respiratory distress. The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator and components.

(e) A private school may accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

(f) A school nurse or trained school personnel shall only administer short-acting bronchodilators and components to students if they have successfully completed training and believe in good faith that the student is experiencing severe respiratory distress, regardless of whether the student has a prescription for a short-acting bronchodilator and components or

has previously been diagnosed with asthma.

(g) The private school shall provide written notice to the parent of each student enrolled in the private school of the school's adopted protocol and must receive prior permission from a student's parent to administer a short-acting bronchodilator or components in a respiratory distress emergency.

(h) The private school and its employees and agents who act in good faith are not liable for any injury arising from the use or non-use of a short-acting bronchodilator or components administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:

1. Unless the trained school personnel's action is willful and wanton.

2. Notwithstanding that the parents of the student to whom the short-acting bronchodilator is administered have not been provided notice or have not signed a statement acknowledging that the private school is not liable.

3. Regardless of whether authorization has been given by the student's parents or by the student's physician, physician assistant, or advanced practice registered nurse.

(i) Any authorized healthcare practitioner who prescribes, or a dispensing pharmacist who fills, a prescription for a short-acting bronchodilator and components for use by a private school is immune from civil liability for any act or omission to

act related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

Section 3. This act shall take effect July 1, 2024.

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 & Human Services Committee

Representative Koster offered the following:

Amendment

Remove everything after the enacting clause and insert:

Section 1. Paragraph (h) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(h) Short-acting bronchodilator ~~Inhaler~~ use.—

1. As used in this paragraph, the term:

a. "Administer" means to give or directly apply a short-acting bronchodilator or components to a student.

b. "Asthma" means a chronic lung disease that inflames and narrows the airways, which can manifest as wheezing, chest tightness, shortness of breath, and coughing.

c. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464.

d. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, which may include spacers, valved holding chambers, or nebulizers.

e. "Respiratory distress" refers to an individual experiencing difficulty breathing, which can be caused by a multitude of medical factors, including chronic diseases such as asthma.

f. "Short-acting bronchodilator" means a beta-2 agonist, such as albuterol, used for the quick relief of asthma symptoms and recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. These bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or compressor device or by a pressured

metered-dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a short-acting bronchodilator recommended in the Guidelines for the Treatment of Asthma.

2. Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator and components ~~metered dose inhaler~~ on their person while in school. The school principal shall be provided a copy of the parent's and physician's approval.

3. An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a public school for use in accordance with this section and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a public school for use in accordance with this section.

4. A public school may acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as defined in s. 499.003 for short-acting bronchodilators and components at fair-market, free, or reduced prices pursuant to a prescription issued in accordance with this section. The short-acting bronchodilators and components must be maintained in a secure location on a school's premises.

5. A participating public school must adopt a protocol developed by a physician licensed under chapter 458 or chapter 459 for the administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator or components. The school district and the protocol must provide guidance for administering short-acting bronchodilators in instances of respiratory distress for a student with a known diagnosis of asthma and if approved by the school district for students with no known diagnosis of asthma.

6. The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator and components.

7. A public school may accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

8. A school nurse or trained school personnel shall only administer short-acting bronchodilators and components to students if they have successfully completed training and believe in good faith that the student is experiencing respiratory distress, regardless of whether the student has a prescription for a short-acting bronchodilator and components or

has previously been diagnosed with asthma.

9. The school district or school shall provide written notice to the parent of each student enrolled in the school district or school of the school's adopted protocol. The public school must receive prior permission from the parent or guardian to administer a short-acting bronchodilator or components to a student.

10. Notwithstanding any other provision of law to the contrary, a school nurse or school personnel of a school district trained in the administration of short-acting bronchodilator who administers or attempts to administer a short-acting bronchodilator in compliance with this section and s. 768.13, and the school district that employs the school nurse or the trained school personnel, are immune from civil or criminal liability as a result of such administration or attempted administration of a short-acting bronchodilator.

11. a. An authorized health care practitioner, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of prescribing a short-acting bronchodilator in accordance with this section.

b. A dispensing health care practitioner or pharmacist, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any

professional licensure statute or rule and is immune from any civil or criminal liability as a result of dispensing a short-acting bronchodilator in accordance with this section.

Section 2. Subsection (18) of section 1002.42, Florida Statutes, is renumbered as subsection (19) and subsection (18) is added to that section, to read:

1002.42 Private schools.—

(18) SHORT-ACTING BRONCHODILATOR USE.—

(a) As used in this paragraph, the term:

1. "Administer" means to give or directly apply a short-acting bronchodilator or components to a student.

2. "Asthma" means a chronic lung disease that inflames and narrows the airways, which can manifest as wheezing, chest tightness, shortness of breath, and coughing.

3. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464.

4. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, which may include spacers, valved holding chambers, or nebulizers.

5. "Respiratory distress" refers to an individual experiencing difficulty breathing, which can be caused by a multitude of medical factors, including chronic diseases such as asthma.

6. "Short-acting bronchodilator" means a beta-2 agonist, such as albuterol, used for the quick relief of asthma symptoms and recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. These bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or compressor device or by a pressured metered-dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a short-acting bronchodilator recommended in the Guidelines for the Treatment of Asthma.

(b) Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator and components on their person while in school. The school principal shall be provided a copy of the parent’s and physician’s approval.

(c) An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a private school for use in accordance with this section, and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a private school for use in accordance with this section.

(d) A private school may acquire and stock a supply of

short-acting bronchodilators and components from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as defined in s. 499.003 for short-acting bronchodilators and components at fair-market, free, or reduced prices pursuant to a prescription issued in accordance with this section. The short-acting bronchodilators and components must be maintained in a secure location on the school premises.

(e) A participating private school must adopt a protocol developed by a physician licensed under chapter 458 or chapter 459 for the administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator or components. The protocol must provide guidance for administering short-acting bronchodilators in instances of respiratory distress for a student with a known diagnosis of asthma and if approved by the private school for students with no known diagnosis of asthma.

(f) The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator and components.

(e) A private school may accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall,

unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

(f) A school nurse or trained school personnel shall only administer short-acting bronchodilators and components to students if they have successfully completed training and believe in good faith that the student is experiencing respiratory distress, regardless of whether the student has a prescription for a short-acting bronchodilator and components or has previously been diagnosed with asthma.

(g) The private school shall provide written notice to the parent of each student enrolled in the private school of the school's adopted protocol. The private school must receive prior permission from the parent or guardian to administer a short-acting bronchodilator or components to a student.

(h) Notwithstanding any other provision of law to the contrary, a school nurse or school personnel of a private school trained in the administration of short-acting bronchodilator who administers or attempts to administer a short-acting bronchodilator in compliance with this section and s. 768.13, and the private school that employs the school nurse or the trained school personnel, are immune from civil or criminal liability as a result of such administration or attempted administration of a short-acting bronchodilator.

(i)1. An authorized health care practitioner, acting in good faith and exercising reasonable care, is not subject to

discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of prescribing a short-acting bronchodilator in accordance with this section.

2. A dispensing health care practitioner or pharmacist, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of dispensing a short-acting bronchodilator in accordance with this section.

Section 3. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 891 Health Care Provider Accountability
SPONSOR(S): Select Committee on Health Innovation, Giallombardo and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 952

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	22 Y, 0 N, As CS	Guzzo	Calamas
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Nursing homes provide 24-hour a day nursing care, case management, health monitoring, personal care, social activities, respite care, and physical, occupational, and speech therapy to those who are ill or physically infirm. Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act in part II of chapter 408, F.S., and under the individual authorizing statutes for nursing homes in part II of chapter 400, F.S.,

CS/HB 891 requires nursing homes to report to AHCA any common ownership the facility or its parent company shares with a staffing or management company, a vocational or physical rehabilitation company, or any other entity that conducts business within the facility. Common ownership means, in relevant part, an ownership interest of 5 percent or more held by the entity in the facility or by the facility in the entity. The bill requires facilities to report this information electronically as an element of the data required to be reported in the Florida Nursing Home Uniform Reporting System. AHCA must annually publish on its website all common ownership reported in the preceding year.

The bill also requires AHCA to submit an annual report to the Governor and the Legislature on the success of the Personal Care Attendant (PCA) training program, which was created by the Legislature in 2021, to create an additional path for an individual to become a certified nursing assistant (CNA). The report must include:

- The number of PCAs who take and subsequently pass the CNA exam after the four months of initial employment with a facility;
- Any adverse actions related to patient care involving PCAs; and
- The number of new CNAs employed and remaining each year after being employed as PCAs.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Nursing Homes

Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S., which contains uniform licensing standards for all 29 types of facilities and providers licensed by AHCA. In addition, nursing homes must comply with the requirements contained in the individual authorizing statutes of part II of chapter 400, F.S., which includes unique provisions beyond the uniform criteria.

Nursing Home Uniform Reporting System

Nursing homes are required to annually submit actual audited, financial experience including expenditures, revenues, and statistical measures to AHCA's Florida Nursing Home Uniform Reporting System (NHURS).[1] The data may be based on internal financial reports that are certified to be complete and accurate by the chief financial officer of the nursing home, and must include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings.[2]

Disclosure of Ownership Interest (State)

The Act requires applicants for licensure, including applicants for nursing home licensure, to submit to AHCA the name, address, and social security number, or individual taxpayer identification number if a social security number cannot be legally obtained, of:[3]

- The applicant;
- The administrator or a similarly titled person who is responsible for the day-to-day operation of the facility;
- The financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider;
- Each person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; and
- Each person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.

Current Florida law does not require nursing homes to report to AHCA any common ownership the facility or its parent company shares with staffing or management companies, vocational or physical rehabilitation companies, or any other companies that conduct business within the facility.

Disclosure of Ownership Interest (Federal)

The federal Centers for Medicare and Medicaid Services (CMS) recently published a final rule implementing additional disclosure requirements for nursing homes certified to provide Medicare or Medicaid.[4] According to CMS, "over the years CMS has become increasingly concerned about the quality of care at nursing homes, especially those owned by private equity companies and other types of investment firms. Academic research suggests that ownership of nursing homes by private equity

[1] S. 408.061(5), F.S.
[2] *Id.*
[3] Ss. 408.806(1), F.S., and 408.803(7), F.S.
[4] 42 C.F.R., § 424.502 (Nov. 17, 2023).

companies and other types of investment firms can be associated with worse resident outcomes, and merits closer scrutiny."[5]

The rule requires all Medicare and Medicaid certified nursing homes to report to CMS and the relevant state Medicaid agencies additional information about their ownership and management structures. Specifically, nursing homes must submit certain information with their application for initial enrollment and upon revalidation, including information on any person or entity who does any of the following:[6]

- Exercises operational, financial, or managerial control over the facility or a part thereof;
- Provides policies or procedures for any of the operations of the facility;
- Provides financial or cash management services to the facility;
- Leases or subleases real property to the facility;
- Owns a whole or part interest equal to or exceeding five percent of the total value of such real property;
- Provides management or administrative services;
- Provides management or clinical consulting services; or
- Provides accounting or financial services to the facility.

For each disclosable party above, the nursing facilities must report the organizational structure of such entity. This requirement varies by business structure, as follows: [7]

- For a corporation – the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds five percent.
- For a limited liability company – the members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company.
- For a general partnership – The partners of the general partnership.
- For a limited partnership – The general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent.
- For a trust – The trustees of the trust.

Personal Care Attendant Training Program

In the initial stages of the COVID-19 pandemic, nursing homes struggled to maintain adequate staffing levels.[8] To address the staffing challenges caused by the pandemic, AHCA temporarily approved the creation of the personal care attendant (PCA) training program.[9] A PCA is an individual who has not fulfilled the necessary requirements to become a certified nursing assistant (CNA), but may assist nursing home residents with certain tasks after completion of required training.[10] This allows them to develop the skills to become a CNA while receiving on the job experience. Like all applicants for certification as a CNA, a PCA is required to pass the CNA competency exam, but their PCA training

[5] Centers for Medicare & Medicaid Services, *Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Definitions of Private Equity Companies and Real Estate Investment Trusts for Medicare Providers and Suppliers* (Nov. 15, 2023), available at https://www.cms.gov/newsroom/fact-sheets/disclosures-ownership-and-additional-disclosable-parties-information-skilled-nursing-facilities-and-0 (last visited January 30, 2024).
[6] 42 C.F.R., § 424.502 *"Additional Disclosable Party"* (1)-(3).
[7] 42 C.F.R., § 424.502 *"Organizational Structure"*
[8] Noelle Denny-Brown, Denise Stone, Burke Hays, and Dayna Gallaghe/U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, *COVID-19 Intensifies Nursing Home Workforce Challenges* (Oct. 19, 2020), available at https://aspe.hhs.gov/basic-report/covid-19-intensifies-nursing-home-workforce-challenges (last visited January 30, 2024).
[9] Memorandum from the Agency for Health Care Administration to the Florida Health Care Association and Florida Leading Age (Mar. 28, 2020), available at https://www.fhca.org/images/uploads/pdf/Personal_Care_Attendent.pdf (last visited January 30, 2024). *See also* Memorandum from the Agency for Health Care Administration to the Florida Health Care Association and Florida Leading Age (Sep. 9, 2020), available at https://www.fhca.org/images/uploads/pdf/PCA_letter_9-8-20_1.pdf (last visited January 30, 2024).
[10] S. 400.211(2)(d), F.S.

substitutes for the 120-hour CNA training program.[11] A PCA must become certified within four months of initial employment.[12]

In 2021, the Legislature codified the temporary PCA training program, with modifications to align it with current practice for CNAs.[13] The goal of the PCA training program is to enable the PCA to further obtain skills and training from their employer toward successfully passing the CNA exam.[14] The PCA must attain certification as a CNA within four months of initial employment.[15]

Completion of all training and documentation requirements for PCA candidates is the ultimate responsibility of the nursing home.[16] Training must consist of 16 hours of classroom instruction and eight hours of supervised simulation in which the PCA candidate is required to demonstrate competency in all areas of training.[17] The facility must maintain a record of all PCA candidates who complete training and must provide the names of all PCAs working in the facility to AHCA upon request.[18]

Effect of the Bill

CS/HB 891 requires nursing homes to report to AHCA any common ownership the facility or its parent company shares with a staffing or management company, a vocational or physical rehabilitation company, or any other entity that conducts business within the facility. Common ownership means, in relevant part, an ownership interest of 5 percent or more held by the entity in the facility or by the facility in the entity. The bill requires facilities to report this information electronically as an element of the data required to be reported in the NHURS. AHCA must annually publish on its website all common ownership reported in the preceding year.

The bill also requires AHCA to submit an annual report to the Governor and the Legislature on the success of the PCA training program, which must include:

- The number of PCAs who take and subsequently pass the CNA exam after the four months of initial employment with a facility;
- Any adverse actions related to patient care involving PCAs; and
- The number of new CNAs employed and remaining each year after being employed as PCAs.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.141, F.S., relating to administration and management of nursing home facilities.
Section 2: Amends s. 400.211, F.S., relating to persons employed as nursing assistants; certification requirements; qualified medication aide designation and requirements.
Section 3: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[11] S. 400.141(1)(w), F.S., and rule 59A-4.1081, F.A.C.
[12] S. 400.211(2)(d), F.S.
[13] Chapter 2021-163, Laws of Fla.
[14] Rule 59A-4.1081(2), F.A.C.
[15] S.400.211(2)(d), F.S.
[16] Rule 59A-4.1081(6), F.A.C.
[17] *Id.*
[18] *Id.*

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

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:

The bill does not necessitate rule-making for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care provider accountability; amending s. 400.141, F.S.; requiring nursing home facilities to report electronically to the Agency for Health Care Administration any common ownership the facility or its parent company share with certain entities; defining the term "common ownership"; requiring the agency to publish on its website specified reports annually; amending s. 400.211, F.S.; requiring the agency to submit annually a report on the success of the personal care attendant program to the Governor and Legislature; providing requirements for the report; providing an effective date.

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

Section 1. Paragraph (x) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(x) Report to the agency any common ownership the facility or its parent company shares with a staffing or management

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

company, a vocational or physical rehabilitation company, or any other entity that conducts business within the nursing home facility. For purposes of this paragraph, "common ownership" means an ownership interest of 5 percent or more held by the entity in the facility or by the facility in the entity. Facilities shall report such information electronically as an element of the data reporting required under s. 408.061(5). The agency shall annually, by January 15, publish on its website all common ownerships reported to the agency in the preceding year.

Section 2. Subsection (2) of section 400.211, Florida Statutes, is amended to read:

400.211 Persons employed as nursing assistants; certification requirement; qualified medication aide designation and requirements.—

(2) The following categories of persons who are not certified as nursing assistants under part II of chapter 464 may be employed by a nursing facility for a single consecutive period of 4 months:

(a) Persons who are enrolled in, or have completed, a state-approved nursing assistant program.

(b) Persons who have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state.

(c) Persons who have preliminarily passed the state's certification exam.

(d) Persons who are employed as personal care attendants and who have completed the personal care attendant training program developed pursuant to s. 400.141(1)(w). As used in this paragraph, the term "personal care attendants" means persons who meet the training requirement in s. 400.141(1)(w) and provide care to and assist residents with tasks related to the activities of daily living.

The certification requirement must be met within 4 months after initial employment as a nursing assistant in a licensed nursing facility. On January 1 of each year, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the success of this program, including, but not limited to, how many personal care attendants take and subsequently pass the certified nursing assistant exam after the 4 months of initial employment with a single nursing facility, any adverse actions related to patient care involving personal care attendants, how many new certified nursing assistants are employed and remain employed each year after being employed as personal care attendants, and the turnover rate of personal care attendants in nursing facilities.

Section 3. This act shall take effect July 1, 2024.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1063 Practice of Chiropractic Medicine
SPONSOR(S): Healthcare Regulation Subcommittee, Hunschofsky
TIED BILLS: **IDEN./SIM. BILLS:** SB 1474

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N, As CS	DesRochers	McElroy
2) Health & Human Services Committee		DesRochers	Calamas

SUMMARY ANALYSIS

Dry needling is a technique that acupuncturists, physical therapists, and other trained healthcare providers use to treat musculoskeletal pain and movement issues. Healthcare providers may incorporate dry needling as a part of a larger pain management point that could include exercise, stretching, massage, and other techniques. Dry needling may help relieve pain and increase range of motion. Depending on the state, dry needling may be performed by licensed physical therapists, athletic trainers, chiropractors, or medical doctors who have been trained in the procedure.

Under current law, the practice of chiropractic medicine is a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body. Specifically, chiropractic medicine targets vertebral subluxations and other malpositioned articulations and structures that interfere with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells of the body.

The Florida Board of Chiropractic Medicine (Board) ensures that every chiropractic physician practicing in Florida meets minimum requirements for safe practice. The Board is responsible for the licensure and quality control of chiropractic professionals to assure competency and safety. Any person desiring to be licensed as a chiropractic physician must apply to DOH to take the licensure examination. The Board has not opined on whether dry needling is within the scope of practice for chiropractic physicians.

CS/HB 1063 authorizes chiropractic physicians to adjust, manipulate, or treat the human body by the use of monofilament intramuscular stimulation, also known as dry needling, treatment for trigger points or myofascial pain.

Current law requires DOH to examine each applicant whom the Board certifies meets the necessary matriculation prerequisites. The bill gives the Board authority to recognize chiropractic physician applicants for licensure if they provide a credential evaluation report from a board-approved organization that the Board deems is equivalent to a bachelor's degree. The effect of this change is to create a licensure pathway for chiropractic physicians to practice in Florida when they obtained their bachelor's level degree at a non-U.S. educational institution of higher education.

The bill has no fiscal impact on state or local governments.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

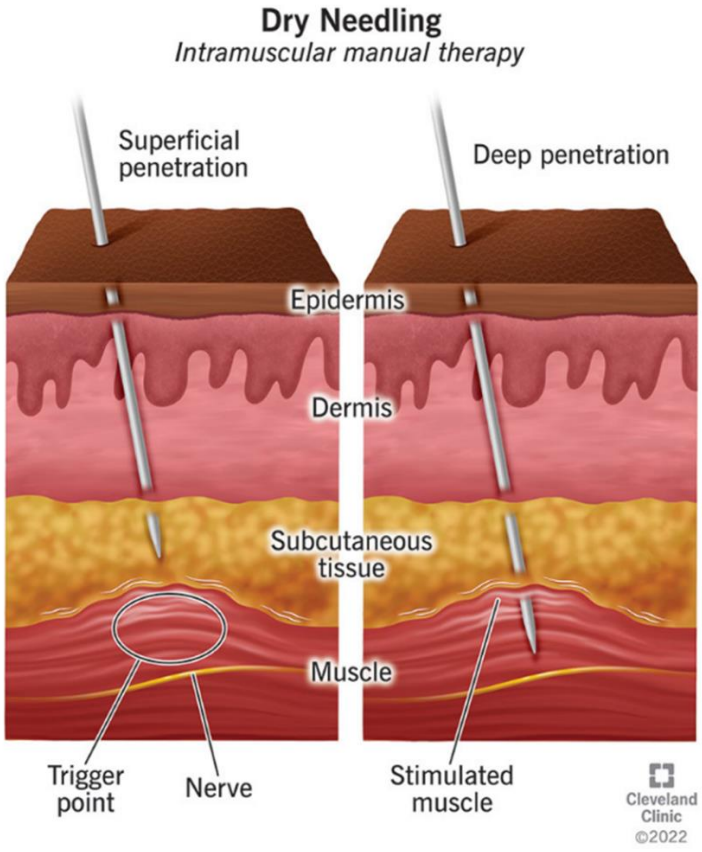
A. EFFECT OF PROPOSED CHANGES:

Background

Dry Needling

Dry needling is a technique that acupuncturists, physical therapists, and other trained healthcare providers use to treat musculoskeletal pain and movement issues. Healthcare providers may incorporate dry needling as a part of a larger pain management point that could include exercise, stretching, massage, and other techniques. With dry needling, a healthcare provider inserts thin, sharp needles through a patient's skin to treat underlying myofascial[1] trigger points. Trigger points are knotted, tender areas that develop in muscles which are highly sensitive and can be painful when touched.[2]

When health providers apply dry needling to muscles and tissues, needles may decrease tightness, increase blood flow, and reduce local and referred pain. Providers use solid needles that do not contain any kind of medication – hence "dry" needling. Dry needling may also be known as intramuscular stimulation. The visual graphic below illustrates how dry needling works.[3]



When a patient overexerts their muscle, the muscle experiences an energy crisis where the muscle fibers cannot access an adequate supply of blood. Without normal blood supply to the muscle, the muscle cannot get the oxygen and nutrients that allow the muscle to return to its normal resting state.

[1] In the word "myofascial," "myo" means "muscle." Fascia is the thin, white connective tissue that wraps around muscles.

[2] The Cleveland Clinic, *Dry Needling*, (last reviewed Feb. 20, 2023) https://my.clevelandclinic.org/health/treatments/16542-dry-needling (last visited Jan. 21, 2024).

[3] *Id*.

Dry needling may stimulate the trigger point to help draw normal blood supply back to flush out the area and release tension.[4]

Dry needling may help relieve pain and increase range of motion. Conditions that dry needling may treat include:[5]

- Joint issues.
- Disk issues.
- Tendonitis.
- Migraine and tension-type headaches.
- Jaw and mouth problems, such as temporomandibular joint (TMJ) disorders.
- Whiplash.
- Repetitive motion disorders, such as carpal tunnel syndrome.
- Spinal issues.
- Pelvic pain.
- Night cramps.
- Phantom limb pain.
- Postherpetic neuralgia, a complication of shingles.

There are certain groups of people who should not receive dry needling. Providers do not recommend the procedure for children under the age of 12 because it can be painful. Other groups who should consult with their physician before receiving dry needling include people who:[6]

- Are pregnant.
- Are not able to understand the treatment.
- Are very afraid of needles (trypanophobia).
- Have compromised immune systems.
- Have just had surgery.
- Are on blood thinners.

The most common side effect of dry needling is soreness during and after treatment. Other side effects are typically minor. They may include:[7]

- Stiffness.
- Bruising at or near the insertion site.
- Fainting.
- Fatigue.
- Risk of infection.

While both dry needling and acupuncture use needles to treat pain, acupuncture treats musculoskeletal pain and dry needling treats muscle tissue with the goal of pain mitigation, deactivating trigger points, and improving movement.[8] Depending on the state, dry needling is performed by licensed physical therapists, athletic trainers, chiropractors, or medical doctors who have been trained in the procedure.

On November 9, 2023, the Florida Board of Chiropractic Medicine convened a board meeting to discuss, in part, the Florida Chiropractic Association (FCA)'s petition for a declaratory statement[9] that asked whether dry needling is within the scope of practice for chiropractic physicians. The Florida Chiropractic Physician Association (FCPA) appeared in support of adding drying needling to the scope

[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Florida Chiropractic Association's Petition for Declaratory Statement Before the Department of Health / Board of Chiropractic Medicine* (Oct. 30, 2023) https://www.fcachiro.org/wp-content/uploads/2023/08/Petition-for-Declaratory-Statement-dry-needling-1.pdf (last visited Jan. 21, 2024).

of practice. The Florida Chiropractic Society (FCS) appeared in opposition to adding dry needling to the scope of practice. After debate, the FCA withdrew their declaratory statement petition, and the Board suspended discussion of whether dry needling is within the scope of practice for chiropractic physicians.[10]

Chiropractic Medicine

The Practice of Chiropractic Medicine

Under current law s. 460.403, F.S., the practice of chiropractic medicine is a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body. Specifically, chiropractic medicine targets vertebral subluxations and other malpositioned articulations and structures that interfere with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells of the body. Left untreated, these abnormalities may cause disease. To mitigate the occurrence of disease, chiropractors adjust, manipulate, and treat the human body to restore the normal flow of nerve impulse which produces normal function and consequent health. The practice of chiropractic medicine further contemplates that chiropractic physicians use specific chiropractic adjustment or manipulation techniques taught in chiropractic colleges accredited by the Council on Chiropractic Education. No person other than a licensed chiropractic physician may render chiropractic services, chiropractic adjustments, or chiropractic manipulations.[11]

Chiropractic physicians may adjust, manipulate, or treat the human body by:

- Manual, mechanical, electrical, or natural methods;
- The use of physical means or physiotherapy, including light, heat, water, or exercise;
- The use of acupuncture; or
- The administration of foods, food concentrates, food extracts, and items for which a prescription is not required.

In addition, chiropractic physicians may apply first aid and hygiene. However, chiropractic physicians are expressly prohibited from prescribing or administering to any person any legend drug except, in emergencies, prescription medical oxygen or topical anesthetics in aerosol form. Chiropractic physicians cannot perform any surgery or practice obstetrics.[12]

Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the chiropractic physician knows or has reason to know that she or he is not competent to perform constitutes grounds for denial of a license or disciplinary action.[13]

The Florida Board of Chiropractic Medicine

The Florida Board of Chiropractic Medicine (Board) ensures that every chiropractic physician practicing in Florida meets minimum requirements for safe practice. The Board is responsible for the licensure and quality control of chiropractic professionals to assure competency and safety.[14] The Board is a division of the Florida Department of Health (DOH) and consists of seven members appointed by the Governor and confirmed by the Senate.[15] Five board members must be licensed chiropractic physicians who are Florida residents and have practiced chiropractic medicine for at least 4 years. The other two board members must be Florida residents who are not, and never have been, licensed as

[10] Florida Board of Chiropractic Medicine, *Board Meeting Minutes, November 9, 2023*, Florida Department of Health (Nov. 9, 2023) https://ww10.doh.state.fl.us/pub/hcpr/Chiropractor/2023/Chiro%20Draft%20Minutes%2011.9.23.pdf (last visited Jan. 21, 2024).
[11] S. 460.403(9)(a), F.S.
[12] S. 460.403(9)(c), F.S.
[13] S. 460.413(1)(t), F.S.
[14] The Florida Board of Chiropractic Medicine, *Homepage*, Florida Department of Health, https://floridaschiropracticmedicine.gov/ (last visited Jan. 21, 2024).
[15] S. 460.404(1), F.S.

chiropractic physicians or members of any closely related profession. At least one board member must be 60 years of age or older.[16]

Any person desiring to be licensed as a chiropractic physician must apply to DOH to take the licensure examination. The nonrefundable application fee is capped at $100, and the National Board of Chiropractic Examiners (NBCE) administers the examination. The examination fee must not exceed $500 plus the actual per applicant cost to DOH for purchase of portions of the examination from NBCE.[17]

DOH examines each application whom the Board certifies has met all of the following criteria:[18]

- Completed the application form and remitted the appropriate fee.
- Submitted proof satisfactory to DOH that the applicant is not less than 18 years of age.
- Submitted proof satisfactory to DOH that the applicant is a graduate of a chiropractic college which is accredited by or has status with the Council on Chiropractic Education or its predecessor agency.
- Regarding matriculation at a chiropractic college, the following requirements apply:
    - Matriculation before July 2, 1990: completed at least 2 years of residence college work, consisting of a minimum of one-half the work acceptable for a bachelor's degree granted on the basis of a 4-year period of study, in a college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education.
    - Matriculation after July 1, 1990: granted a bachelor's degree, based upon 4 academic years of study, by a college or university accredited by an institutional accrediting agency that is a member of the Commission on Recognition of Postsecondary Accreditation.
    - Before matriculation effective July 1, 2000: completed at least 3 years of residence college work, consisting of a minimum of 90 semester hours leading to a bachelor's degree in a liberal arts college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education. In addition, the applicant must have been granted a bachelor's degree from an institution holding accreditation for that degree from an institutional accrediting agency that is recognized by the United States Department of Education.[19]
- Passed the NBCE certification examination in parts I, II, III, and IV with a score approved by the Board.
- Passed the NBCE physiotherapy examination with a score approved by the Board.
- Submitted to DOH a set of fingerprints on a form and under procedures specified by DOH, along with payment in an amount equal to the costs incurred by DOH for the criminal background check of the applicant.

Current law requires applicants to have a bachelor's degree from a school accredited by an agency recognized and approved by the U.S. Department of Education. This prevents chiropractic physicians who obtained their bachelor's level degree at a non-U.S. educational institution of higher education from being considered for licensure in Florida, even if they graduated from a U.S. chiropractic school.

Effect of the Bill

CS/HB 1063 authorizes chiropractic physicians to adjust, manipulate, or treat the human body by the use of monofilament intramuscular stimulation, also known as dry needling, treatment for trigger points or myofascial pain.

[16] S. 460.404(2), F.S.
[17] S. 460.406(1), F.S.
[18] S. 460.406(1), F.S.
[19] The applicant's chiropractic degree must consist of credits earned in the chiropractic program and may not include academic credit for courses from the bachelor's degree.

Current law requires DOH to examine each applicant whom the Board certifies meets the necessary matriculation prerequisites. The bill gives the Board authority to recognize chiropractic physician applicants for licensure if they provide a credential evaluation report from a board-approved organization that the Board deems is equivalent to a bachelor's degree. The effect of this change is to create a licensure pathway for chiropractic physicians to practice in Florida when they obtained their bachelor's degree at a non-U.S. educational institution of higher education.

The bill takes effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amending s. 460.403, F.S., relating to definitions.
Section 2: Amending s. 460.406, F.S., relating to licensure by examination.
Section 3: Providing an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

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 Board has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 24, 2024, the Health Regulation Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Gives the Board of Chiropractic Medicine the power to deem that an applicant's credentials evaluation report issued from a board-approved organization is the education equivalent to a bachelor's degree.
- Makes the effective date upon becoming law.

This analysis is drafted to the amended bill as passed by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to the practice of chiropractic medicine; amending s. 460.403, F.S.; authorizing chiropractic physicians to use dry needling treatments for specified purposes; amending s. 460.406, F.S.; requiring the Board of Chiropractic Medicine to certify certain applicants who provide a specified credentials evaluation report; providing an effective date.

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

Section 1. Paragraph (c) of subsection (9) of section 460.403, Florida Statutes, is amended to read:

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

(9)

(c)1. Chiropractic physicians may adjust, manipulate, or treat the human body by manual, mechanical, electrical, or natural methods; by the use of physical means or physiotherapy, including light, heat, water, or exercise; by the use of acupuncture; by the use of monofilament intramuscular stimulation, also known as dry needling, treatment for trigger points or myofascial pain; or by the administration of foods, food concentrates, food extracts, and items for which a prescription is not required and may apply first aid and

hygiene, but chiropractic physicians are expressly prohibited from prescribing or administering to any person any legend drug except as authorized under subparagraph 2., from performing any surgery except as stated herein, or from practicing obstetrics.

2. Notwithstanding the prohibition against prescribing and administering legend drugs under subparagraph 1. or s. 499.83(2)(c), pursuant to board rule chiropractic physicians may order, store, and administer, for emergency purposes only at the chiropractic physician's office or place of business, prescription medical oxygen and may also order, store, and administer the following topical anesthetics in aerosol form:

a. Any solution consisting of 25 percent ethylchloride and 75 percent dichlorodifluoromethane.

b. Any solution consisting of 15 percent dichlorodifluoromethane and 85 percent trichloromonofluoromethane.

However, this paragraph does not authorize a chiropractic physician to prescribe medical oxygen as defined in chapter 499.

Section 2. Paragraph (d) of subsection (1) of section 460.406, Florida Statutes, is amended to read:

460.406 Licensure by examination.—

(1) Any person desiring to be licensed as a chiropractic physician must apply to the department to take the licensure examination. There shall be an application fee set by the board

not to exceed $100 which shall be nonrefundable. There shall also be an examination fee not to exceed $500 plus the actual per applicant cost to the department for purchase of portions of the examination from the National Board of Chiropractic Examiners or a similar national organization, which may be refundable if the applicant is found ineligible to take the examination. The department shall examine each applicant whom the board certifies has met all of the following criteria:

(d)1. For an applicant who has matriculated in a chiropractic college before July 2, 1990, completed at least 2 years of residence college work, consisting of a minimum of one-half the work acceptable for a bachelor's degree granted on the basis of a 4-year period of study, in a college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education or provides a credentials evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree. However, before being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college after July 1, 1990, must have been granted a bachelor's degree, based upon 4 academic years of study, by a college or university accredited by an institutional accrediting agency that is a member of the Commission on Recognition of Postsecondary Accreditation or provides a credentials evaluation report from a board-approved

organization that deems the applicant's education equivalent to a bachelor's degree.

2. Effective July 1, 2000, completed, before matriculation in a chiropractic college, at least 3 years of residence college work, consisting of a minimum of 90 semester hours leading to a bachelor's degree in a liberal arts college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education or provides a credentials evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree. However, before being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college after July 1, 2000, must have been granted a bachelor's degree from an institution holding accreditation for that degree from an institutional accrediting agency that is recognized by the United States Department of Education or provides a credentials evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree. The applicant's chiropractic degree must consist of credits earned in the chiropractic program and may not include academic credit for courses from the bachelor's degree.

(e) Successfully completed the National Board of Chiropractic Examiners certification examination in parts I, II, III, and IV, and the physiotherapy examination of the National

Board of Chiropractic Examiners, with a score approved by the board.

(f) Submitted to the department a set of fingerprints 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 criminal background check of the applicant.

The board may require an applicant who graduated from an institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractic, or its equivalent, as determined by the board. The board shall establish by rule a passing score.

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

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 & Human Services Committee

Representative Hunschofsky offered the following:

Amendment (with title amendment)

Remove line 23 and insert:

points or myofascial pain, only after completing a 40-hour, in person board approved certification course approved by the Federation of Chiropractic Licensing Boards, Providers of Approved Continuing Education; or by the administration of foods,

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

Remove line 5 and insert:

for specified purposes; requiring certain training and certification; amending s. 460.406, F.S.;

CS/HB 1219

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1219 Dental Insurance Claims
SPONSOR(S): Insurance & Banking Subcommittee, Black
TIED BILLS: **IDEN./SIM. BILLS:** SB 892

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	17 Y, 0 N, As CS	Herrera	Lloyd
2) Health & Human Services Committee		Lloyd	Calamas
3) Commerce Committee			

SUMMARY ANALYSIS

Health insurance serves a vital role in protecting individuals from financial hardships caused by accidents, illnesses, or disabilities. Health insurers and health care providers often interact with one another prior to the delivery of care. An initial interaction often involves a provider seeking verification from an insurer that a patient has active insurance coverage.

If patients seek services for which they are not currently covered, there is no guarantee that a health insurer will pay for those services. For example, a patient may seek service prior to that patient's coverage effective date, after coverage terminates, or during grace period where a patient has not yet paid the premium. If that patient was not eligible for coverage at the time of service delivery, a medical claim may be denied. Sometimes, a provider may have already verified that the patient had coverage, provided services based on that verification, and in some cases, already received payment from the insurer. Retroactive denials can result in the provider or the patient covering the financial costs, despite a verification of eligibility.

Dental insurance is subject to regulation by the Office of Insurance Regulation (OIR) and the Department of Financial Services (DFS) for adherence to insurance laws and fair practices and by the Agency for Health Care Administration (AHCA) for quality of care issues.

The federal Patient Protection and Affordable Care Act (Act) also provides consumer protections to those individuals who purchase qualified plans, and for those insureds who receive a federal premium tax credit towards that coverage. For those with tax credits enrolled in certain plans, extended grace periods exist for non-payment of premiums. Federal regulations require coverage of services during a portion of that grace period.

The bill, applicable to health insurers, prepaid limited health service organizations (PLHSOs), and health maintenance organizations (HMOs):

- Prohibits mandating credit card payments as the sole means of reimbursement for dental services.
- Requires notice by insurers to dental providers before electronic fund transfers.
- Allows dental providers to establish alternative fee schedules for covered services once a dental patient has reached certain contractual limitations.
- Establishes criteria for claims denial under prior authorizations under specific circumstances.
- Mandates OIR enforcement of claims payment provisions.
- Prohibits the waiver, voiding, or nullification of specified claims payment and prior authorization contractual provisions in contracts with dental providers.

The bill may have a positive impact on state government revenue and local governments. It has an indeterminate economic impact on the private sector and state government expenditures.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[1] Individuals purchase health insurance coverage with the purpose of managing anticipated expenses related to health and protecting themselves from unexpected medical bills or large health care costs. Many individuals access health care coverage as a benefit of employment where the employer may contribute towards the cost of the employee's coverage while others may purchase coverage directly from an insurance company or from places like the Act's marketplace.[2] Health insurance may be purchased on an individual basis or for an entire family.

Managed Care

Managed care is the most common delivery system for medical care today by health insurers.[3] Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[4] In return for this limited choice, however, medical care is usually less costly to the patient due to lower out of pocket costs and the managed care network's ability to control the cost and utilization of health care services. Some common forms of managed care are preferred provider organizations[5] (PPO), exclusive provider organizations (EPOs),[6] and health maintenance organizations[7] (HMO). For services to be covered at the lowest out of pocket cost to the insured, the insured must utilize the managed care plan's network of providers, except in cases of an emergency. Different managed care companies have a variety of network and out of pocket cost arrangements based on an individual's or family's needs.

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida, as well as licensing, rates, policy forms, market conduct, claims, issuances of certificates of authority, solvency, viatical statements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[8] .The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[9] For managed care entities to receive a license from OIR, the entity must meet financial guidelines, benefits, and policy standards as established under Chapter 690.154, F.A.C.

The Agency for Health Care Administration

[1] S. 624.603, F.S.
[2] *See* Healthcare.gov, *How to apply and enroll, Apply for Health Insurance | HealthCare.gov* (last visited Feb. 12, 2024).
[3] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers,* available at: https://www.myfloridacfo.com/docs-sf/consumer-services-libraries/ (last visited Jan. 26, 2024).
[4] *Id*.
[5] S. 627.6471, F.S.
[6] S. 627.6472, F.S.
[7] Part I of ch. 641, F.S.
[8] S. 20.121(3)(a), F.S.
[9] The Code is comprised of chs. 624-632, 634-636, 641, 642, 648, and 651, F.S. *See* S. 624.3161, F.S.

The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state,[10] and regulates the quality of care provided by managed care organizations under ch. 408, F.S

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) operate within a regulatory framework dually overseen by the OIR and AHCA. To offer a commercial health insurance plan in Florida, an HMO must obtain a license from the OIR[11] and a Certificate of Authority from AHCA. An HMO is also required to become accredited by one of the state's approved organizations: National Committee for Quality Assurance, National Association for Ambulatory Health Care, and American Accreditation HealthCare Commission.[12] Certificates of authority are granted by AHCA, if found to be compliant with the certification process, on a county by county basis or for a portion of a county.[13]

Most managed care enrollment in Florida is through an HMO. For the last quarterly submission to AHCA in September 2023, Florida HMOs reported over 8.2 million enrollees as shown in the table below.[14]

HMO Enrollment	
Group Type	**Third Qtr 2023**
Small Group	203,821
Large Group	476,358
Individual	1,909,616
Other	8,559
Healthy Kids	109,385
Medicaid	3,763,314
Medicare	1,763,708
Federal Employees	6,207
GRAND TOTAL:	**8,240,968**

These plans provide comprehensive healthcare services to members for a fixed monthly premium.[15] Members typically select a primary care physician from within the HMO's network, who serves as the main point of contact for all healthcare needs and referrals to specialists.[16] HMOs maintain networks of healthcare providers, including primary care physicians, specialists, hospitals, and other healthcare facilities.[17] Members are generally required to receive care from within the HMO's network, with exceptions for emergencies or authorized out-of-network care, for services to be covered.[18]

[10] AHCA, *About the Agency for Health Care Administration*, https://ahca.myflorida.com/about-the-agency-for-health-care-administration (last visited Jan. 26, 2024).
[11] S. 641.21(1), F.S.
[12] Agency for Health Care Administration, *Health Care Provider Certificate Process,* *Health Care Provider Certificate Process (myflorida.com)* (last visited Feb. 13, 2024).
[13] Id.
[14] Florida Office of Insurance Regulation, *Managed Care Report: Quarterly Data Summary as of September 30, 2023,* *managed-care-report-2023-q3-15dec2023.pdf (floir.com)* (last visited Feb. 13, 2024).
[15] Medicare, What's an HMO? https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Jan. 26, 2024).
[16] *Id*.
[17] S. 641.19(12), F.S.
[18] Medicare, *What's an HMO?*, https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Jan. 26, 2024).

Florida law, under ch. 641, provides various consumer protections, including guaranteed access to emergency services, coverage for essential health benefits[19] mandated by the Act,[20] and the right to appeal coverage decisions made by the HMO.[21]

Prepaid Limited Health Service Organizations

Prepaid limited health service organizations (PLHSO) provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment authorized under ch. 636, F.S. Limited health services include:

- Ambulance;
- Dental;
- Vision;
- Mental health;
- Substance abuse;
- Chiropractic;
- Podiatric; and
- Pharmaceutical.

Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

Preferred Provider Organizations

Authorized under ch. 627, a preferred provider organization (PPO) includes those licensed health insurers who have contracted with providers or a group of providers, directly or indirectly for an alternative or reduced rate of payment to provide a list of covered services to policyholders under the insurer's plan.[22] A PPO provider must distribute to its policyholders a list of preferred providers and make the list available on its website. Insureds have a choice of who may provide their services, but usually pay a lower deductible and less other out of pockets costs if they choose a preferred provider.[23]

Exclusive Provider Organizations

Exclusive provider organizations are another form of managed care that is also dually regulated by the OIR and the AHCA. Regulated under chapter 627, an EPO is a group of providers who have signed written contracts with an insurer to provide services to the insured's subscribers. Before the EPO can issue a policy; however, the AHCA must issue a Certificate of Authority which specifically includes approval of the EPO's plan of operation. In addition to a plan of operation, an EPO must maintain a quality assurance program and the ability to resolve complaints and grievances from its subscribers.[24]

Dental Insurance Plans

Dental insurance is a contract with an insurance company which provides benefits that can help lower the costs of dental treatment.[25] In exchange for a premium paid, dental insurance typically covers the cost of preventive care, such as routine cleanings and check-ups, but other care such as restorative treatments like fillings and extractions is usually covered at lower percentage rates, such as 80 percent,

[19] Under the Patient Protection and Affordable Care Act, all non-grandfathered plans in the non-group and small group private health insurance markets must offer a core package of health insurance services known as the essential health benefits (EHBs). While not specifying the details of these benefits and services, there are ten general categories including coverage for pediatric dental services. Adult dental benefits are not an essential health benefit. *See Essential Health Benefits,* Healthcare.gov, *Find out what Marketplace health insurance plans cover | HealthCare.gov* (last visited Feb. 13, 2024).
[20] Patient Protection and Affordable Care Act, (March 23, 2010), P.L. 111-141, as amended.
[21] Consumer Services, *Health Insurance & HMO Overview*, https://www.myfloridacfo.com/division/consumers/understanding-insurance/health-insurance-and-hmo-overview (last visited Feb. 12, 2024).
[22] S. 627.6471, F.S.
[23] Supra, note 30.
[24] Agency for Health Care Administration, *Exclusive Provider Organizations (EPOs),* *Exclusive Provider Organizations (EPOs) (myflorida.com)* (last visited Feb. 12, 2024).
[25] Humana, *What is dental insurance?"* *How Does Dental Insurance Work? | Humana* (last visited Feb. 12, 2024).

requiring higher out of pocket costs by the patient.[26] Some plans may also offer coverage for more extensive procedures like root canals, crowns, and orthodontic treatment, although coverage levels and limitations can vary widely depending on the specific plan.[27] Many dental plans may also impose an annual benefit maximum (dollar amount).

Consumers in Florida have the option to purchase dental insurance plans on the individual market or through group plans offered by employers, other organizations, or on the Act's marketplace.[28] An Act's dental plan cannot be purchased separately; it can only be purchased if a health plan is bought at the same time.[29] Some of the marketplace plans offer health plans which include dental benefits under a single premium amount. For children aged 18 or younger, dental coverage is an essential health benefit and therefore, dental coverage must be available either as part of the health plan or offered as a separate plan. While dental coverage must be available to children, it is not required that it be purchased.[30]

The availability and cost of dental insurance coverage can vary depending on factors such as age, location, and the extent of coverage desired.[31] In addition to traditional dental insurance plans, some employees may also have access to dental discount plans, health reimbursement accounts, flexible spending accounts, or health savings accounts (HSAs) that can help employees save for major and minor dental expenses and offset the cost of dental care.[32] Some of these options allow employees to deposit funds pre-tax through pay-roll deductions to potentially receive a tax break on predictable out of pocket costs.

Insurer Contracts with Dentists

A contract between an insurer and dentist licensed under ch. 466, for the provision of services to a subscriber of the HMO, PLHSO, or other insurer may not require the dentist to provide services to the subscriber of the HMO at a fee set by the HMO unless such services are covered services under the applicable contract.[33] The term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, or for which a reimbursement would be available but for the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.[34] Currently, if an insured patient exhausts his benefits or reaches a limitation, but the contract is still active, the dental patient is entitled to pay the price negotiated between the plan and the dental provider for that covered service, not a fee unilaterally set by the dental provider.

Health Insurance Contracts

All health insurance policies issued in the state of Florida, with the exception of certain self-insured policies,[35]must meet certain requirements that are detailed throughout the Florida Insurance Code. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[36]

Non-Payment of Premiums

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[26] HealthPartners, *What Does Dental Insurance Cover?*, https://www.healthpartners.com/blog/what-does-dental-insurance-cover/ (last visited Jan. 26, 2024).
[27] *Id*.
[28] Health Care, *Dental Coverage in the Marketplace*, https://www.healthcare.gov/coverage/dental-coverage/ (last visited Feb. 12, 2024).
[29] *Id.*
[30] *Id.*
[31] *Id*.
[32] MyBenefits, *Health Savings Account*, https://www.mybenefits.myflorida.com/health/savings_and_spending_accounts (last visited Jan. 26, 2024).
[33] S. 641.315(11), F.S.
[34] S. 641.315(11), F.S.
[35] The Employment Retirement Security Act of 1974 (ERISA). 29 U.S.C. ch 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida.
[36] S. 627.413(1)(d), F.S.

Responsibilities of insured patients are also reflected in insurance contracts. Contracts set premium payment schedules and require that payments must be made in a timely fashion. In cases where this requirement is not met, a health insurer or HMO may cancel coverage for nonpayment of premiums after a statutory grace period.[37]

Before cancellation can occur, however, covered patients are protected by grace periods that extend the time frame in which premium payments may be submitted. A grace period is a period of time following the due date of a premium payment in which the insurance policy remains in force, even if the premium payment has not been made. The grace periods for policies or contracts issued in Florida are set in the Insurance Code,[38] and vary based on the premium payment schedule.

Pursuant to ss. 627.608 and 641.31, F.S., insurance policies and health maintenance contracts stay in force during grace periods. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may deny any medical claims incurred during the grace period. When a claim is denied at a later date, it is referred to as a retroactive denial.

The Insurance Code is silent on whether the insurer or HMO may advise a health care provider that a patient has not paid the applicable premium, and that the policy or health maintenance contract may be terminated in the future, possibly resulting in a retroactive claim denial.

Prompt Payment

Current law governs prompt payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, under ss. 627.6131 and 641.3155, F.S., respectively.[39] These provisions detail the rights and responsibilities of insurers, HMOs, and providers for the payment of medical claims. The statutes provide a process and timeline for providers to pay, deny, or contest the claim, and also prohibit an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than one year after the date the claim is paid.[40]

Federal Patient Protection and Affordable Care Act

The Act introduced a set of claims-related requirements for insurers offering plans through the federally-facilitated and state-based insurance exchanges. The Act guarantees access to coverage and mandates certain essential health benefits, among other directives.[41] To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans on a state or federal exchange.[42]

According to the 2023 Market Report by the Florida Health Insurance Advisory Board, total enrollment in Florida's commercial health insurance market is 4,671,680 individuals which represents an increase

[37] SS. 627.6043(1) and 641.3108(2), F.S.
[38] SS. 627.608 and 641.31(15), F.S.; The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of a HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.
[39] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organization, and individual and group contracts that only provide direct payments to dentists.
[40] SS. 627.6131(11) and 641.3155(10), F.S.
[41] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended several provisions of the PPACA, was enacted on March 30, 2010. Together these two Acts are known as PPACA.
[42] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line (FPL) for their family size. For residents of one of the 48 contiguous states or Washington, D.C., 100 percent of the FPL for a family of 4 is $31,200; at 400 percent of the FPL for a family of 4 is $124,800. *See* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *HHS Poverty Guidelines for 2024*, available at: detailed-guidelines-2024.pdf (hhs.gov) (last visited Feb. 12, 2024).

of over eight percent from the prior year.[43] The largest group in this market has individual coverage, over 2.9 million Floridians, an increase of 16 percent over 2022, and the vast majority of this coverage has been purchased through the ACA marketplace.[44] For the 2024 Open Enrollment period, Florida's total number of ACA marketplace plan selections from new and continuing consumers was 4,211,902 plan selections, the highest number of selection among all states, federal or state based exchanges.[45]

Non-Payment of Premiums – Federal Law

All qualified health plans (QHP)[46] in the ACA marketplace are required to establish standard policies for the termination of enrollees due to the non-payment of premiums. The policy must be applied uniformly to enrollees in similar situations.[47] If an enrollee is delinquent with a premium payment, the QHP must notify the enrollee of the delinquency promptly and without undue delay, within 10 business day of the date from which the insurer should have discovered the delinquency.[48]

Individual health insurance plans purchased via the exchanges with a federal premium tax credit are not subject to the grace periods in Florida law. Instead, the Act requires insurers and HMOs to provide subscribers in these plans, a grace period of at least three consecutive months before cancelling the policy or contract if the enrollee previously paid at least a binder payment or the first month's premium payment.[49] The binder payment is due no earlier than the coverage effective date and no later than 30 calendar days from the coverage effective date.[50]

During the first month of the grace period, the insurer must pay all appropriate claims for services provided.[51] During the grace period, the insurer must also notify the Department of Health and Human Services of the non-payment and notify providers of the possibility for denied claims when an enrollee is in the second and third months of a grace period.[52] For the second and third months, an insurer may pend claims and then must notify affected providers that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer may deny the payment of claims incurred during the second and third months.[53]

Payment Methods for Health Care Claims

In March 2022, the Department of Health and Human Services (HHS) issued guidance for covered entities[54] on the payment of health care claims by health plans through the use of virtual credit cards (VCC) and whether these transactions met the federal regulatory standards for electronic transactions. Instead of sending a paper check or an electronic transmission of payments, some health plans paid providers by sending out a single use credit card number or VCC. The provider was then required to manually enter VCC numbers in order to receive payment incurring transaction fees on each payment processed. HHS guidance concluded that payment by VCC was permitted; however, to meet the standards, the health plans must maintain certain privacy and confidentiality and transaction standards,

[43] Florida Health Insurance Advisory Board, *2023 Market Report, fhiab-2023-market-report---adopted-(12-15-23).pdf (floir.com)* (last visited Feb. 13, 2024).
[44] *Id.*
[45] Centers for Medicare and Medicaid Services, *Marketplace 2024 Open Enrollment Period Report: Final National Snapshot (January 24, 2024)*, available at Marketplace 2024 Open Enrollment Period Report: Final National Snapshot | CMS (last visited Feb. 13, 2024).
[46] A "qualified health plan" is a plan that has been certified to meet the minimum standards of participation under 45 CFR §156.200 and is recognized as a QHP by the exchanges through which the plan is offered. Those standards include compliance with Exchange process and procedures, benefit design standards, licensure compliance in state where products are sold, in good standing in states where licensed products are sold, implementation of a quality improvement strategy or strategies consistent with the Act's goals, payment of applicable user fees, and compliance with reinsurance, risk corridors, and risk adjustment requirements.
[47] 45 CFR § 156.270(c).
[48] 45 CFR § 156.270 (f).
[49] 45 CFR §156.270(d).
[50] Centers for Medicare and Medicaid Services, *Health Plan Coverage Effectuation Webinar Training: Payment, Grace Periods, and Termination (Navigator Training materials – January 2024),* available at Health Plan Coverage Effectuation_Webinar_Jan_2024 (cms.gov) (last visited Feb. 12, 2024).
[51] 45 CFR §156.270(d)(1).
[52] 45 CFR §156.270(d).
[53] 45 CFR §156.270(d)(3).
[54] A "covered entity" is defined at 45 CFR §160.103, as a health plan, a health plan clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction.

including a one-to-one relationship between each electronic remittance advice (ERA) and electronic funds transfer (EFT).[55] Once a plan submits a payment using the required standard with the specifications, any intermediaries acting on behalf of the health plan, including health care clearinghouses, financial institutions, and payment vendors, cannot alter, amend, or omit any information.[56]

Federal regulations also require that if a health plan pays providers via a VCC, the provider must be able to continue to request payments via EFT through the Automated Clearinghouse (ACH) Network using regulatory and ERA transaction standards, and the health plan is required to comply with those requests.[57] When a provider makes this request, the health plan must comply, regardless of whether the provider is in the plan's network or not or otherwise not affiliated with the plan.[58]

If the provider has made a request to a health plan to conduct transactions via EFT and ERA using the adopted standards, and the provider believes that the health plan has not used or complied with those standards or operating rules, the provider may file a complaint against the health plan with the federal Centers for Medicare and Medicaid Services.[59]

Regulation of Dentists

Dentists are licensed by the Board of Dentistry within the Department of Health under ch. 466, F.S. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[60] Dentists may delegate certain tasks[61] to dental hygienists and dental assistants, but a patient's "dentist of record" retains primary responsibility for all dental treatment on the patient.[62]

Any person wishing to practice dentistry must meet specified requirements and apply to the Department of Health (DOH) for licensure. Applicants must sit for and pass three examinations prior to licensure:[63]

- The National Board of Dental Examiners dental examination (NBDE);
- A practical examination, which is the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc.;[64] and
- A written examination on Florida laws and rules regulating the practice of dentistry and dental hygiene.

To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.[65]

Once licensed, dentists must maintain professional liability insurance or provide proof of financial responsibility of an equal amount. If the dentist obtains professional liability insurance, the coverage must be at least $100,000 per claim, with a minimum annual aggregate of at least $300,000.[66] Alternatively, a dentist may maintain an unexpired, irrevocable letter of credit in the amount of $100,000

[55] Department of Health and Human Services, *Go to Guidance: Guidance on health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted HIPAA standards for Health Care Electronic Funds Transfer (EFT) and Remittance Advice (ERA) transactions; 45 CFR §§162.1601 and 162.1602(d),* available at Virtual Credit Cards (VCCs) and Electronic Funds Transfers (EFT) Guidance Letter (cms.gov) (last visited Feb. 12, 2024).
[56] *Id.*
[57] *Supra,* note 76 and 45 CFR §162.925(a)(1).
[58] *Supra,* note 76.
[59] *Id.*
[60] S. 466.003(2)-(3), F.S.
[61] S. 466.024, F.S.
[62] S. 466.018, F.S.
[63] S. 466.006, F.S.
[64] Rule 64B5-2.013, F.A.C.
[65] S. 466.006(2), F.S.
[66] Rule 64B5-17.011(1), F.A.C.

per claim, with a minimum aggregate availability of credit of at least $300,000.[67] The professional liability insurance must provide coverage for the actions of any dental hygienist supervised by the dentist.[68] However, a dentist may be exempt from maintaining professional liability insurance if he or she:[69]

- Practices exclusively for the federal government or the State of Florida or its agencies or subdivisions;
- Is not practicing in this state;
- Practices only in conjunction with his or her teaching duties at an accredited school of dentistry or in its main teaching hospitals; or
- Demonstrates to the Board that he or she has no malpractice exposure in this state.

There are currently 17,193 dentists with active licenses to practice in Florida,[70] and 41 out-of-state registered telehealth dentists.[71]

Effects of the Bill

The bill modifies contracts between the dental provider and insurers, including HMOs, PPOs, and PLHSOs, to address requirements for the payment of dental claims, provision of covered services after an insured has reached a certain threshold, and nullification of existing contract provisions, if in conflict with any of the new provisions.

Regulation of Payment Methods

The bill prohibits health insurers under chs. 627, 636, and 641 from specifying reimbursement of claims through credit card payments as the only acceptable method of payment in a contract with a dentist licensed under ch. 466. Currently, state law is silent on acceptable forms of payment between a health plan and a provider in a private contract; however federal law has established specific standards for covered entities, which includes both the plan and the provider, as to how such transaction must be carried out, under what type of specifications for the privacy and security of the information involved. Federal regulations have also prohibited covered entities from exclusively requiring payment via VCCs, and require that a health plan honor a provider's request for payment via the ACH and EFT process.

If using the EFT process, the bill establishes a requirement these insurers to provide written notice to dentists at least ten days prior to making payments, to outline any associated fees, and present alternative payment methods with clear instructions for how to select an alternative method of payment.

Claims Denial

Under the bill, an insurer could not deny any claim submitted by a dentist licensed under ch. 466 for procedures specifically included in a prior authorization, unless:

- Benefit limitations were reached subsequent to the issuance of the prior authorization;
- Inadequate documentation was submitted to support the originally authorized claim;
- Changes in the patient's condition or provision of new procedures post-authorization rendered the prior authorized procedure medically unnecessary;
- Changes in the patient's condition or provision of new procedures would have required disapproval under the terms and conditions of the patient's plan at the time of prior authorization; or
- Responsibility for the claim belonged to another payor for payment, prior payment was already made to the dentist for the procedures in question, request was a fraudulent claim submission, or patient shown as ineligible at the time of service.

[67] Rule 64B5-17.011(2), F.A.C.
[68] Rule 64B5-17.011(4), F.A.C.
[69] Rule 64B5-17.011(3), F.A.C.
[70] *See*, Department of Health *License Verification* web search. Available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited January 26, 2024).
[71] *Id*.

Existing state law does not establish which party is responsible for claims incurred when verification of eligibility or prior authorization is received by a dental provider for a specific service from an insurer, the service is provided, and afterwards, the claim is denied because the patient was not covered at the time of service. The patient may not have been covered for a variety of reasons, such as a timing difference between when the dental provider's office called to verify eligibility and receive a prior authorization for the service, or the patient may have been in the premium grace period.

The changes proposed in the bill would limit the circumstances in which a claim could be denied to those situations where benefits were exhausted, the service was no longer medical necessary or would not have been approved because of concern for the patient's condition, or there were other payment validity concerns. In those cases where prior authorization had been received, the patient had not exceeded his or her benefits, and the covered services were still medical services, the claim could not be denied.

Reimbursement of Covered Services

In contracts between plans licensed under chs. 627, 636, and 641 and dentists, the bill modifies how insured individuals who reach a contractual limitation, such as a deductible, coinsurance, waiting period, annual or lifetime maximum, frequency limitations, alternative benefits payments, or any other limitation may be billed by dentists for covered services under the contract. The individual is still considered a covered individual under the contract; however, the modification removes the requirement for the dentist to honor the fees set by the health insurer for covered services once the insured has reached the designated contractual limitation, and the revised provision permits the dentist to set a different fee schedule.

Enforcement and Non-Waiver Provisions

For each of the new provisions applicable to the contract between an insurer and a dentist, the bill includes a component stating that none of the new provisions can be waived or nullified by contract, and any existing contractual clause conflicting with these provisions, is null and void. This provision applies to each type of coverage addressed by the bill.

The bill authorizes OIR to enforce its provisions, and authorizes the FSC to adopt rules for implementation.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6131, F.S., relating to payment of claims.
Section 2: Amends s. 627.6474, F.S., relating to provider contracts.
Section 3: Amends s. 636.032, F.S., relating to acceptable payments.
Section 4: Amends s. 636.035, F.S., relating to provider agreements
Section 5: Amends s. 641.315, F.S., relating to provider contracts.
Section 6: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

None. The Division of State Group Insurance within the Department of Management Services concluded the bill will not increase costs for the state employee group health plan.[72]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The bill could negatively impact local government expenditures through potential increases in premium costs, resulting from any additional payments for dental claims which would have been previously denied but for which denial is prohibited by the bill, and from increased administrative costs. The amount of impact depends on the level of coverage and the practices of each dental plan.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have a negative economic impact on the insurance industry, depending on the amount and type of claims denial activity in which they engage, and also due to increased administrative costs.

The bill may have a positive economic impact on dental care providers, which may experience increased revenue under the bill's claims payment regulations.

D. FISCAL COMMENTS:

None.

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:

The bill may implicate s. 10, Art. I, Florida Constitution, which provides in relevant part, " No law impairing the obligation of contracts shall be passed." This provision empowers the courts to strike laws that retroactively burden or alter contractual relations. Art. I., sec. 10 of the United States Constitution provides in relevant part that "No state shall…pass any …law impairing the obligation of contracts."

The bill seeks to enjoin existing contracts from voiding, nullifying, or otherwise waiving by contract any contractual clause in existence which would conflict with the changes proposed to contracts between dental plans and dental providers. Any existing contract provisions that are in conflict would be nullified under the bill.

In *Pomponio v. Claridge of Pompano Condominium, Inc.,*[73] the Florida Supreme Court stated that some degree of flexibility has developed over the last century in interpreting the contract clause in order to ameliorate the harshness of the original rigid application used by the United States Supreme Court. The court set forth several factors in balancing whether a state law operates as a substantial impairment of a contractual relationship. The severity of the impairment measures the height of the hurdle the state legislation must clear. The court stated that if there is minimal

[72] Email correspondence with Jake Holmgreen, Department of Management Services, Jan. 29, 2024, on file with the Health and Human Services Committee.
[73] *Pomponio v. Claridge of Pomponia Condominum, Inc.*, 378 So. 2d 774, 776 (Fla. 1979).

alteration of contractual obligations the inquiry can end at its first stage. Severe impairment can push the inquiry to a careful examination of the nature and purpose of the state legislation. The factors to be considered are:

- Was the law enacted to deal with a broad, generalized economic or social problem;
- Does the law operate in an area that was already subject to state regulation at the time the contract was entered into; and
- Is the law's effect on the contractual relationships temporary or is it severe, permanent, immediate, and retroactive?[74]

If legislation adjusts the rights and responsibilities of the contracting parties, the Court has previously concluded that the correct standard to be employed is that "an impairment may be constitutional if it is reasonable and necessary to serve an important public purpose."[75] Additionally, another relevant factor for consideration would be whether an alternative means could have been adopted to achieve the same goal because "a State is not free to impose a drastic impairment when an evident and more moderate course would serve its purposes equally well."[76]

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to the FSC to implement its provisions. OIR has sufficient rulemaking authority under current law to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 1, 2024, the Insurance & Banking Subcommittee considered the bill, adopted an amendment, reported the bill favorably as a committee substitute. The amendment removed a proposed authorization for health insurers to charge a fee for value-added services related to ACH transfers.

The analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.

[74] *Id.* at 779.
[75] *United States Trust Co. v. New Jersey,* 431 U.S. 1, 25 (N.J., 1977).
[76] *Id.* at 31.

A bill to be entitled

An act relating to dental insurance claims; amending s. 627.6131, F.S.; prohibiting a contract between a health insurer and a dentist from containing certain restrictions on payment methods; requiring a health insurer to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a health insurer from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction; authorizing the Office of Insurance Regulation of the Financial Services Commission to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health insurer from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 627.6474, F.S.; revising the definition of the term "covered services"; amending s. 636.032, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; requiring the prepaid limited health service organization to make certain notifications

before paying a claim to a dentist through electronic funds transfer; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; revising the definition of the term "covered services"; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 641.315, F.S.; revising the definition of the term "covered service"; prohibiting a contract between a health maintenance organization and a dentist from containing certain restrictions on payment methods; requiring the health maintenance organization to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a health maintenance organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction;

authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health maintenance organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; providing an effective date.

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

Section 1. Subsections (20) and (21) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(20)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not specify credit card payment as the only acceptable method for payments from the health insurer to the dentist.

(b) At least 10 days before a health insurer pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the health insurer shall notify the dentist in writing of all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(21)(a) A health insurer may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the

claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health insurer by the dentist, patient, or other person not related to the insurer.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service, and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 2. Subsection (2) of section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(2) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain a provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the insured's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Section 3. Section 636.032, Florida Statutes, is amended

to read:

636.032 Acceptable payments.—

(1) Each prepaid limited health service organization may accept from government agencies, corporations, groups, or individuals payments covering all or part of the cost of contracts entered into between the prepaid limited health service organization and its subscribers.

(2)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber may not specify credit card payment as the only acceptable method for payments from the prepaid limited health service organization to the dentist.

(b) At least 10 days before a prepaid limited health service organization pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the prepaid limited health service organization shall notify the dentist in writing of all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the prepaid limited health service organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A prepaid limited health service organization that

pays a claim to a dentist through Automatic Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

Section 4. Subsection (13) of section 636.035, Florida Statutes, is amended, and subsection (15) is added to that section, to read:

636.035 Provider arrangements.—

(13) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the prepaid limited health service organization may not contain a provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available

under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(15)(a) A prepaid limited health service organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized

procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the dental service claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the prepaid limited health service organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service, and the prepaid limited health service organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this

subsection.

Section 5. Subsection (11) of section 641.315, Florida Statutes, is amended, and subsections (13) and (14) are added to that section, to read:

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance

organization to the dentist.

(b) At least 10 days before a health maintenance organization pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the health maintenance organization shall notify the dentist in writing of all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the health maintenance organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health maintenance organization that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(14)(a) A health maintenance organization may not deny any claim subsequently submitted by a dentist licensed under chapter

466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health maintenance organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service, and the health maintenance organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) The subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 6. This act shall take effect July 1, 2024.

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 & Human Services Committee

Representative Black offered the following:

Amendment (with title amendment)

Remove lines 62-339 and insert:

Section 1. Subsections (20) and (21) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(20)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not require credit card payment as the only acceptable method for payments from the health insurer to the dentist.

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including but not limited

to, virtual credit card payments, a health insurer shall:

1. Notify the dentist in writing of the fees, if any, associated with the electronic funds transfer.

2. Notify the dentist in writing of the available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method, if any.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for value-added services related to the ACH transfer, including but not limited to, transaction management, data management, and portal services.

(d) This subsection applies to contracts delivered, issued, or renewed on or after January 1, 2025.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(21)(a) A health insurer may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health insurer by the dentist,

patient, or other person not related to the insurer.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service.

e. The services were provided during the grace period established under s. 627.608 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(b) This subsection applies to all contracts delivered, issued, or renewed on or after January 1, 2025.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection

Section 2. Section 636.032, Florida Statutes, is amended to read:

636.032 Acceptable payments.—

(1) Each prepaid limited health service organization may accept from government agencies, corporations, groups, or individuals payments covering all or part of the cost of contracts entered into between the prepaid limited health service organization and its subscribers.

(2)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the

provision of services to a subscriber may not require credit card payment as the only acceptable method for payments from the prepaid limited health service organization to the dentist.

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including but not limited to, virtual credit card payments, a health insurer shall:

1. Notify the dentist in writing of the fees, if any, associated with the electronic funds transfer.

2. Notify the dentist in writing of the available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method, if any.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for value-added services related to the ACH transfer, including but not limited to, transaction management, data management, and portal services.

(d) This subsection applies to contracts delivered, issued, or renewed on or after January 1, 2025.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

Section 3. Subsection (15) is added to section 636.035, Florida Statutes, to read:

(15)(a) A prepaid limited health service organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the dental service claim was due to one

of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the prepaid limited health service organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service.

e. The services were provided during the grace period established under s. 636.016 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(d) This paragraph applies to contracts delivered, issued, or renewed on or after January 1, 2025

Section 4. Subsections (13) and (14) of section 641.315, Florida Statutes, are added to read:

641.315 Provider contracts.—

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance

organization may not require credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist.

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including but not limited to, virtual credit card payments, a health insurer shall:

1. Notify the dentist in writing of the fees, if any, associated with the electronic funds transfer.

2. Notify the dentist in writing of the available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method, if any.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for value-added services related to the ACH transfer, including but not limited to, transaction management, data management, and portal services.

(d) This subsection applies to all contracts delivered, issued, or renewed on or after January 1, 2025.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(14)(a) A health maintenance organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health maintenance organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service.

e. The services were provided during the grace period established under s. 641.31 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(b) This subsection applies to all contracts delivered, issued, or renewed, on or after January 1, 2025.

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

Remove lines 19-41 and insert:

amending s. 636.032, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; requiring the prepaid limited health service organization to make certain

notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction; providing an effective date for contractual changes; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; providing an effective date for contractual changes; authorizing the commission to adopt rules; amending s. 641.315, F.S.; prohibiting

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1259 Provider of Cardiovascular Services
SPONSOR(S): Select Committee on Health Innovation, Andrade and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1612

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Guzzo	Calamas
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

The Agency for Health Care Administration (AHCA) licenses three levels of hospital programs for Adult Cardiovascular Services (ACS), including adult inpatient diagnostic cardiac catheterization, Level I ACS, and Level II ACS.

Licensed Level I ACS programs provide diagnostic and therapeutic cardiac catheterization services, including percutaneous cardiac intervention (PCI involves placing a stent in an artery to allow the flow of blood), on a routine and emergency basis. Level I ACS programs must have written transfer agreements with at least one hospital licensed as a Level II ACS program, which must allow the safe transfer of a patient within 60 minutes. Level I ACS programs are not allowed to perform open heart surgery, use rotational or other atherectomy devices, or treat chronic total occlusions.

The bill amends licensure requirements for Level I ACS programs. Specifically, it authorizes programs to perform adult PCI for treatment of chronic total occlusions, and to use rotational or other atherectomy devices, or electrophysiology when performing PCI.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Licensure

The Agency for Health Care Administration (AHCA) regulates hospitals under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, and other definitive medical treatment.[2]

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals which must include minimum standards to ensure:[3]

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules;
- Licensed facility beds conform to minimum space, equipment, and furnishing standards;
- Each hospital has a quality improvement program designed according to standards established by their current accrediting organization;
- Licensed facilities make available on their websites, and in hard copy format upon request, a description of and a link to their patient charge and performance outcome data;
- All hospitals providing organ transplantation, neonatal intensive care services, inpatient psychiatric services, inpatient substance abuse services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by AHCA.

Separate standards may be provided for general and specialty hospitals, ambulatory surgical centers, and statutory rural hospitals.[4] The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

Percutaneous Cardiac Intervention

Percutaneous cardiac intervention (PCI), commonly known as coronary angioplasty or angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease.[5] PCI uses a catheter to insert a stent in the heart to reopen blood vessels that have been narrowed by plaque build-up, a condition known as atherosclerosis.[6] The catheter is threaded through blood vessels into the heart where the coronary artery is narrowed.[7] Once in place, a balloon tip covered with a stent is inflated to compress

[1] S. 395.002(12), F.S.
[2] *Id.*
[3] S. 395.1055(1), F.S.
[4] S. 395.1055(2), F.S.
[5] George A Stouffer, III, and Pradeep K Yadav, *Percutaneous Coronary Intervention (PCI)*, MEDSCAPE, Oct. 12, 2016, available at http://emedicine.medscape.com/article/161446-overview (last visited January 31, 2024).
[6] Percutaneous coronary intervention (PCI or angioplasty with stent), Heart and Stroke, available at https://www.heartandstroke.ca/heart/treatments/surgery-and-other-procedures/percutaneous-coronary-intervention (last visited January 31, 2024).
[7] *Id.*

the plaque and expand the stent.[8] When the plaque is compressed and the stent is in place, the balloon is deflated and withdrawn, leaving the stent to hold the artery open.[9]

In 2014, the Society for Cardiovascular Angiography and Interventions, the American College of Cardiology (ACC) and the American Heart Association (AHA) issued an Expert Consensus document on PCI without on-site surgical backup, which acknowledged advances and best practices in PCI performed in hospitals without on-site surgery (Level I adult cardiovascular services facilities).[10] The Expert Consensus document noted that while PCI peaked in 2006, PCIs at hospitals without on-site surgery have increased since 2007.[11] The Expert Consensus document recommends the PCI programs without on-site surgery have experienced nursing and technical laboratory staff with training in interventional laboratories.[12] The Expert Consensus document continues to recommend PCI procedures should not be performed in facilities performing fewer than 200 procedures, with few exceptions.[13] The Expert Consensus document also recommends that a 95% success rate and a less than 5% complication rate are more important factors than overall volume of procedures performed.[14]

Increasingly, these types of procedures are being done outside of a hospital setting, in office-based cardiac catheterization laboratories and ambulatory surgical centers (ASCs). In 2020, the US Centers for Medicare & Medicaid Services expanded coverage to include PCI in an ASC setting.[15] The new rule also removed the requirements for ASCs to have transfer agreements with acute care hospitals, and for physicians practicing at ASCs to have privileges at the acute care hospital with which they have a transfer agreement.

There are no state regulations for ASCs regarding these types of procedures other than compliance with building codes for treatment rooms. Studies have demonstrated that PCIs performed at sites without Level II surgery support have low rates of complications and similar outcomes to PCIs performed with surgery on site.[16]

Adult Cardiovascular Services

In 2007, certificate of need (CON)[17] review was eliminated for adult cardiovascular services (ASC) and such services are currently only subject to licensure requirements.[18] Section 395.1055, F.S., establishes three levels of hospital program licensure for ACS, including adult inpatient diagnostic cardiac catheterization, Level I ACS, and Level II ACS.

[8] *Id.*
[9] *Id.*
[10] Gregory J. Dehmer, et al., *SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup*, Society for Cardiovascular Angiography and Interventions, the American College of Cardiology Foundation, and the American Heart Association, Inc., (Mar. 17, 2014) available at https://www.ahajournals.org/doi/10.1161/CIR.0000000000000037 (last visited January 31, 2024).
[11] *Id.*
[12] *Id.*
[13] *Id.* The Expert Consensus document cites data from a 2010-2011 National Cardiovascular Data Registry showing that half (49%) of reporting facilities performed fewer than 400 PCIs annually and of these, 65% of the facilities without on-site surgery backup had an annual case volume of less than 200 PCIs.
[14] *Supra*, note 10.
[15] 42 C.F.R. § 410.49.
[16] Alice K. Jacobs, M.D., Sharon-Lise T. Normand, Ph.D., Joseph M. Massaro, Ph.D., et al., *Nonemergency PCI at Hospitals with or without On-Site Cardiac Surgery*, New England Journal of Medicine (April 2013), available at https://www.nejm.org/doi/full/10.1056/nejmoa1300610 (last visited January 31, 2024), *see also* Thomas Aversano, M.D., Cynthia C. Lemmon, R.N., B.S.N., M.S., and Li Liu, M.D., *Outcomes of PCI at Hospitals with or without On-Site Cardiac Surgery*, New England Journal of Medicine (May 2012), available at https://www.nejm.org/doi/full/10.1056/nejmoa1114540 (last visited January 31, 2024).
[17] A certificate of need is a written statement issued by AHCA evidencing community need for a new, converted, or expanded nursing home, intermediate care facility for the developmentally disabled, or hospice. *See* s. 408.036, F.S.
[18] Ch. 2007-214, Laws of Fla.

Level I ACS Programs

Licensed Level I ACS programs provide diagnostic and therapeutic cardiac catheterization services, including PCI, on a routine and emergency basis, but do not have on-site open-heart surgery capability.[19] Level I ACS programs must have written transfer agreements with at least one hospital licensed as a Level II ACS program, which must allow the safe transfer of a patient within 60 minutes.[20]

Licensed Level I ACS programs must comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.[21] Additionally, they must comply with the reporting requirements of the American College of Cardiology-National Cardiovascular Data Registry.[22]

Level I ACS programs are prohibited from performing the following procedures:[23]

- Any therapeutic procedure requiring transseptal puncture;
- Any lead extraction for a pacemaker, biventricular pacer or implanted cardioverter defibrillator;
- Any rotational or other atherectomy devices; and
- Treatment of chronic total occlusions.

As of January 10, 2024, there were 69 hospitals licensed to provide Level I ACS.[24]

Effect of the Bill

CS/HB 1259 authorizes Level I ACS programs to perform adult PCI for treatment of chronic total occlusions,[25] and to use rotational or other atherectomy devices,[26] or electrophysiology[27] when performing PCI.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[19] S. 395.1055(18)(b)1.
[20] Rule 59A-3.246(2)(c), F.A.C.
[21] Rule 59A-3.246(2)(a)5., F.A.C.
[22] Rule 59A-3.246(2)(a)7., F.A.C.
[23] Rule 59A-3.246(2)(a)10., F.A.C.
[24] Agency for Health Care Administration, Agency Analysis of 2024 HB 1259 (Jan. 10, 2024).
[25] When a coronary artery becomes completely blocked – not simply narrowed – it is called a total occlusion, and if complete blockage lasts for three months or longer, it is referred to as "chronic total occlusion." *See* Yale Medicine, Chronic Total Occlusion Overview, available at https://www.yalemedicine.org/conditions/chronic-total-occlusion (last visited January 31, 2024).
[26] An atherectomy device is a catheter with a blade or laser on its end used to remove plaque from an artery. Types of atherectomy devices include: rotational atherectomy (tiny blades cut plaque in a circular motion); excisional atherectomy (a single blade cuts plaque in one direction); laser ablation atherectomy (a laser removes the plaque); and orbital atherectomy (a spinning tool that works like sandpaper to remove plaque). *See* Cleveland Clinic, PAD: Atherectomy; Overview What is Atherectomy for PAD?, available at https://my.clevelandclinic.org/health/treatments/17310-pad-atherectomy (last visited January 24, 2024).
[27] Electrophysiologic studies or "EP testing" is used to diagnose and treat abnormal heart rhythms. It involves the insertion of a catheter into a blood vessel that leads to the heart which inserts electrodes in the heart to measure electrical activity in the heart. *See* Cleveland Clinic, Electrophysiology (EP) Study, available at https://my.clevelandclinic.org/health/diagnostics/23054-electrophysiology-study (last visited January 31, 2024).

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

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:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 2, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Restores current law related to licensure standards for diagnostic cardiac catheterization programs, Level I ACS programs, and Level II ACS programs.
- Authorizes rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions for Level I ACS programs.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.

A bill to be entitled

An act relating to providers of cardiovascular services; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration to adopt rules that allow a Level I Adult Cardiovascular Services program to use certain tools and treatments; providing an effective date.

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

Section 1. Paragraph (a) of subsection (18) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) The establishment of two hospital program licensure levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery, including rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions, and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

Section 2. This act shall take effect July 1, 2024.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 1267 Economic Self-sufficiency
SPONSOR(S): Appropriations Committee, Children, Families & Seniors Subcommittee, Anderson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 7052

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	16 Y, 0 N, As CS	Osborne	Brazzell
2) Appropriations Committee	28 Y, 0 N, As CS	Potvin	Pridgeon
3) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

Public assistance programs help low-income families meet their basic needs, such as housing, food, and utilities. The most commonly utilized public assistance programs in Florida include Medicaid, the Supplemental Nutrition Assistance Program (SNAP) or food assistance, and the Temporary Assistance for Needy Families (TANF) Temporary Cash Assistance (TCA) program. In Florida, the majority of the participants in these programs are children.

While the goal of public assistance programs is, generally, to ensure that a family's basic needs are met and facilitate economic advancement, families often exit programs before they are truly capable of maintaining self-sufficiency. A benefit cliff occurs when a modest increase in wages results in a net loss of income due to the reduction in or loss of public benefits that follows. Benefit cliffs create a financial disincentive for low-income individuals to earn more income due to the destabilization and uncertainty that often results from a loss in benefits, especially when the benefit lost was essential to a parent's ability to reliably work.

The most significant benefit cliffs occur when a family loses housing or child care assistance. While a family is receiving housing and/or child care benefits, the costs for these necessities are a defined, affordable share of the family's income, but those expenses can significantly increase when the family enters the private market.

CS/CS/HB 1267 revises various components of the TANF, SNAP, and School Readiness (SR) programs. The bill creates case management as a transitional benefit for families transitioning off of TCA. The bill allows TCA recipients to count hours spent on GED coursework toward their work requirement. The bill also requires the use of a financial forecasting tool to assist people receiving public benefits in navigating self-sufficiency.

The bill requires the Department of Children and Families to expand mandatory SNAP Employment and Training participation to include adults ages 18-59, who do not have children under age 18 in the home or otherwise qualify for an exemption.

The bill creates the School Readiness Subsidy Program to provide financial assistance to families who no longer qualify for school readiness program funding. The new program will mitigate the child care cliff effect for families transitioning to economic self-sufficiency.

For Fiscal Year 2024-2025, the bill provides $23,076,259 in nonrecurring funds from the General Revenue Fund to the Department of Education to implement the School Readiness Subsidy Program. *See* Fiscal Comments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Public Assistance Programs

Public assistance programs help low-income families meet their basic needs, such as housing, food, and utilities.[1] The social safety net for American families depends on the coordination of a complex patchwork of federal, state, and local funding and program administration.[2] Through various programs, public assistance is capable of helping families keep children in their family home through economic difficulties[3] and reducing the material hardship that has been linked to negative outcomes in children;[4] as well as driving the economy in times of market downturns[5] and supporting the career advancement of low-income adults striving to break the cycle of intergenerational poverty.[6] But while these outcomes have been shown to be feasible, the positive impact of public assistance programs can be inhibited by incongruent policies and the intricacies of overlapping federal programs.

The process of facilitating the broad, conceptual goals of public assistance programs involves several federal programs with different levels of flexibility that allow the states to tailor the programs to their own needy populations. The eligibility criteria and participation requirements for each program vary dependent upon a combination of state and federal policy.

The most commonly utilized public assistance programs in Florida include Medicaid, the Supplemental Nutrition Assistance Program (SNAP), also known as food assistance or food stamps, and the Temporary Assistance for Needy Families (TANF) Temporary Cash Assistance (TCA) program. In Florida, the majority of the participants in one or more of these programs are children. In May 2021, 54 percent of children in Florida were participating in at least one of these public assistance programs.[7]

Barriers to Economic Self-Sufficiency

Benefit Cliffs

[1] National Conference of State Legislatures. *Introduction to Benefits Cliffs and Public Assistance Programs* (2023). Available at https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs (last visited January 17, 2024).
[2] Brookings Institute. *State Social Safety Net Policy: How are States Addressing Economic Need?* (2023). Available at https://www.brookings.edu/events/state-social-safety-net-policy-how-are-states-addressing-economic-need/ (last visited January 17, 2024).
[3] Providing assistance to needy families so that children can be cared for in their own homes is one of the four purposes of the TANF program. *See*, Office of Family Assistance. *About TANF* (2022). Available at https://www.acf.hhs.gov/ofa/programs/tanf/about (last visited January 17, 2024). *See also*, Gennetian, L. & Magnuson, K. *Three Reasons Why Providing Cash to Families with Children is a Sound Policy Investment* (2022). Center on Budget and Policy Priorities. Available at https://www.cbpp.org/research/income-security/three-reasons-why-providing-cash-to-families-with-children-is-a-sound (last visited January 17, 2024).
[4] Karpman, M., Gonzalez, D., Zuckerman, S., & Adams, G. *What Explains the Widespread Material Hardships among Low-Income Families with Children?* (2018). Urban Institute. Available at https://www.urban.org/sites/default/files/publication/99521/what_explains_the_widespread_material_hardship_among_low-income_families_with_children_0.pdf (last visited January 17, 2024).
[5] Vogel, S., Miller, C., & Ralston, K. *Impact of USDA's Supplemental Nutrition Assistance Program (SNAP) on Rural and Urban Economies in the Aftermath of the Great Recession* (2021). US Department of Agriculture. *Economic Research Service Economic Research Report Number 296* (2021). Available at https://ssrn.com/abstract=3938336 (last visited January 17, 2024).
[6] Duncan, G. & Holzer, H, *Policies that Reduce Intergenerational Poverty* (2023). The Brookings Institute. Available at https://www.brookings.edu/articles/policies-that-reduce-intergenerational-poverty/ (last visited January 17, 2024).
[7] Office of Program Policy Analysis and Government Accountability (OPPAGA). *Research Memorandum: Economic Self-Sufficiency*, Research Product 10. On file with the Health & Human Services Committee.

The broad goal underlying public assistance programs is to ensure that a family's basic needs are met during times of financial hardship and facilitate the economic advancement of low-income families; however, families often exit programs before they are truly capable of maintaining self-sufficiency. A benefit cliff occurs when a modest increase in wages results in a net loss of family resources due to the reduction in or loss of public benefits that follows.[8]

Benefit cliffs create a financial disincentive for low-income individuals to earn more income due to the destabilization and uncertainty that often results from a loss in benefits, especially when the benefit lost was essential to a parent's ability to work consistently, such as a child care subsidy.[9] The fear of an impending benefit cliff can be sufficient to discourage career advancement. The complex nature of public assistance programs contributes to workers struggling to understand the timing and magnitude of benefits loss. This uncertainty, paired with economic insecurity, can prevent individuals from seeking or accepting opportunities for career advancement.[10]

The most significant benefit cliffs occur when a family loses housing or child care assistance. While a family is receiving housing and/or child care benefits, the costs for these necessities are a defined, affordable share of the family's income, but those expenses can skyrocket when the family enters the private market where there are no controls on prices.[11] The chart below reflects an example of a family's possible financial situation. A family receiving cash assistance and a child care subsidy can experience a sudden, significant drop in net resources when their income makes them ineligible for these benefits.

FAMILY NET FINANCIAL RESOURCES
(INCOME + PUBLIC ASSISTANCE - TAXES - EXPENSES)

The chart below shows how changes in income affect family net financial resources. As income increases, the programs shown in the chart above phase out. As a result, the net financial resources may flatten (reflecting *a benefits plateau*) or even dip (reflecting *a benefits cliff*) as income increases.

Benefits depicted: TCA and School Readiness for a family of 3 in Flagler County

Child Care

The lack of child care services presents a significant barrier to employment for the parents of small children. It is estimated that only 44 percent of U.S. families with children under the age of 13 can

[8] Altig, D., Ilin, E., Ruder, A., Terry, E. *Benefits Cliffs and the Financial Incentives for Career Advancement: A Case Study of the Health Care Services Career Pathway* (2020). The Federal Reserve Bank of Atlanta. Available at https://www.atlantafed.org/community-development/publications/discussion-papers/2020/01/31/01-benefits-cliffs-and-the-financial-incentives-for-career-advancement (last visited January 16, 2024).
[9] *Id*.
[10] Federal Reserve Bank of Atlanta. *Career Ladder Identifier and Financial Forecaster (CLIFF)*. Available at https://www.atlantafed.org/economic-mobility-and-resilience/advancing-careers-for-low-income-families/cliff-tool (last visited January 19, 2024).
[11] Ettinger de Cuba, S. *Cliff Effects and the Supplemental Nutritional Assistance Program* (2017). Federal Reserve Bank of Boston. Available at https://www.bostonfed.org/publications/communities-and-banking/2017/winter/cliff-effects-and-the-supplemental-nutrition-assistance-program.aspx#ft7 (last visited January 16, 2024).

afford the full price of childcare without having to sacrifice other basic needs such as housing, food, health care, and transportation.[12]

The lack of available affordable, appropriate, high-quality child care impacts how parents participate in the workforce, as well as children's cognitive and social development. Parents who work may have to work fewer hours or turn down higher-paying jobs in order to remain eligible for child care assistance programs, while other parents may elect to stay at home with small children when child care is not accessible.[13] There is a significant economic impact associated with parents opting out of the workforce, or choosing to remain in lower-paying jobs, due to the inaccessibility of quality, affordable child care.[14]

For parents who choose to remain in the workforce, the inability to afford high-quality child care can have negative effects on children's development. Parents may have to reduce their standard of living in order to afford child care and continue to work; if this results in the sacrifice of adequate housing and health care, this can adversely affect parents as well as children and lead to financial and psychological stress.[15] Alternatively, parents may choose lower-quality child care that is more affordable. The quality of child care, however, matters for the healthy development of children at early ages.[16] Low-quality child care can adversely affect children's task attentiveness and emotional regulation;[17] whereas high-quality child care has been associated with positive outcomes such as fewer reports of problem behaviors, higher cognitive performance, and higher language skills.[18]

Education

A person's level of educational attainment has a significant impact on the employment opportunities available to that person and their capacity for upward economic mobility throughout their life. A person who attained at least a high school credential, or the equivalent,[19] has access to further education and professional development that are not available to individuals who did not complete high school. Higher levels of educational attainment are associated with higher employment rates and higher median earnings.[20] For example, in 2022 the employment rate for adults ages 25 to 34 ranged from 61 percent

[12] Birken, B., Ilin, E., Ruder, A., & Terry, E. *Restructuring the Eligibility Policies of the Child Care and Development Fund to Address Benefit Cliffs and Affordability: Florida As a Case Study* (2021). Federal Reserve Bank of Atlanta. Available at https://www.atlantafed.org/-/media/documents/community-development/publications/discussion-papers/2021/01-restructuring-the-eligibility-policies-of-the-child-care-and-development-fund-to-address-benefit-cliffs-and-affordability-2021-06-18.pdf

[13] Morrissey, T.W. *Child care and parent labor force participation: a review of the research literature* (2017). Review of Economics of the Household. 15, 1–24. https://doi.org/10.1007/s11150-016-9331-3

[14] For more information on this economic impact, *see*, Altig, D., Ilin, E., Ruder, A., & Terry, E. *Benefits Cliffs and the Financial Incentives for Career Advancement: A Case Study of a Health Care Career Pathway.* (2020). Federal Reserve Bank of Atlanta. Available at https://www.atlantafed.org/community-development/publications/discussion-papers/2020/01/31/01-benefits-cliffs-and-the-financial-incentives-for-career-advancement (last visited January 16, 2024); *and* Council of Economic Advisers. *The Role of Affordable Child Care in Promoting Work Outside the Home*. (2019). Available at https://trumpwhitehouse.archives.gov/wpcontent/uploads/2019/12/The-Role-of-Affordable-Child-Care-in-Promoting-Work-Outsidethe-Home-1.pdf. (last visited January 19, 2024).

[15] *Supra*, note 12.

[16] *Id.*

[17] Gialamas, A., Mittinty, M., Sawyer, M., Zubrick, S., & Lynch, J. *Child Care Quality and Children's Cognitive and Socio-Emotional Development: an Australian Longitudinal Study* (2014). Early Child Development and Care 184 (7): 977–997.

[18] National Institute of Child Health and Human Development (NICHD). Early Child Care Research Network. T*he NICHD Study of Early Child Care and Youth Development* (2005). Available at https://www.nichd.nih.gov/sites/default/files/publications/pubs/documents/seccyd_06.pdf (last visited January 19, 2024).

[19] The most commonly recognized equivalent to a high school diploma is the General Educational Development (GED) credential. GED credentials are an alternative credential for individuals who did not complete high school. The GED is accepted by most colleges and universities that require a high school diploma for admission, and most companies that have positions requiring a high school diploma accept the GED as an alternative credential. For more information see, Stark, P. & Noel, A. *Trends in High School Dropout and Completion Rates in the United States: 1972-2012*. (2015). US Department of Education, National Center for Education Statistics. Available at https://eric.ed.gov/?id=ED557576 (last visited January 19, 2024).

[20] US Department of Education. *Report on the Condition of Education 2023* (2023). Available at https://nces.ed.gov/pubs2023/2023144rev.pdf (last visited January 7, 2023).

among individuals who had not completed high school[21] to 87 percent for those with a bachelor's degree or higher.[22]

The lack of a high school diploma, or the equivalent, complicates the transition from adolescence to adulthood. Among young adults who do not pursue post-secondary education, the possession of a high school diploma is associated with significantly more time spent employed during the early years of adulthood.[23] Additionally, the lack of a high school diploma or an equivalent credential is the top risk factor for homelessness among young adults.[24] There are a variety of other long-term negative outcomes associated with dropping out of high school, such as lower median income,[25] higher rates of criminal activity, higher rates of unemployment and incarceration, and poorer health.[26]

At the individual level, there are a variety of unique personal, social, and economic reasons may lead an individual to not complete high school. Generally, however, people who drop out of high school are more likely to have grown up in low-income, single-parent households, and lived in distressed communities than their counterparts who complete high school.[27] For low-income youths living in areas with high rates of income inequality, this has been tied to a perceived lower rate of return on investment for continuing high school.[28] This phenomenon is consistent with the patterns of intergenerational poverty in the US.

Intergenerational Poverty

Intergenerational poverty occurs when individuals who grew up in families with incomes below the poverty line are themselves poor as adults. Children living in families with low incomes face an array of challenges that place them at a much higher risk of experiencing poverty in adulthood compared with other children.[29] As a result, roughly one-third of children who grow up poor in the US will also experience poverty as adults.[30]

There are numerous social and cultural factors that contribute to intergenerational poverty, but key drivers influencing intergenerational mobility include:[31]

- Education, spanning from early education to career training;
- Children's health and access to health care;
- Family employment, income, and wealth; and
- Crime and involvement with the criminal justice system.

Recidivism

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[21] "High school completion" includes those who graduated from high school with a diploma, as well as those who completed a high school equivalency program, such as obtaining GED credentials.
[22] *Supra*, note 20.; *see also*, Stark, P. & Noel, A. *Trends in High School Dropout and Completion Rates in the United States: 1972-2012*. (2015). US Department of Education, National Center for Education Statistics. Available at https://eric.ed.gov/?id=ED557576 (last visited January 19, 2024).
[23] McDaniel, M. & Kuehn, D. *What Does a High School Diploma Get You? Employment, Race, and the Transition to Adulthood* (2013). The Review of Black Political Economy. 40, 371-399. https://doi.org/10.1007/s12114-012-9147-1
[24] Morton, M.H., Dworsky, A., & Samuels, G.M. *Missed opportunities: Youth homelessness in America. National estimates* (2017). Chicago, IL: Chapin Hall at the University of Chicago. Available at https://www.chapinhall.org/wp-content/uploads/ChapinHall_VoYC_NationalReport_Final.pdf (last visited January 9, 2024).
[25] Stark, P. & Noel, A. *Trends in High School Dropout and Completion Rates in the United States: 1972-2012*. (2015). US Department of Education, National Center for Education Statistics. Available at https://eric.ed.gov/?id=ED557576 (last visited January 19, 2024).
[26] Lansford, J., Dodge, K., Pettit, G., & Bates, J., *A Public Health Perspective on School Dropout and Adult Outcomes: A Prospective Study of Risk and Protective Factors from Age 5 to 27 Years* (2016). Journal of Adolescent Health. 58. 652-658. http://dx.doi.org/10.1016/j.jadohealth.2016.01.014
[27] *Supra*, note 23.
[28] Kearney, M. & Levine, P. *Income Inequality, Social Mobility, and the Decision to Drop Out of High School*. (2016). Brookings Papers on Economic Activity. Available at https://www.brookings.edu/wp-content/uploads/2016/03/kearneytextspring16bpea.pdf (last visited January 10, 2024).
[29] National Academies of Sciences, Engineering, and Medicine. *Reducing Intergenerational Poverty* (2023). Washington, DC: The National Academies Press. https://doi.org/10.7226/27058.
[30] *Id*. For comparison, 17% of people who did not grow up in low-income environments will experience poverty as adults.
[31] *Id*. See also, Duncan, G. & Holzer, H. *Policies that Reduce Intergenerational Poverty* (2023). Brookings Institute. Available at https://www.brookings.edu/articles/policies-that-reduce-intergenerational-poverty/ (last visited January 19, 2024).

Recidivism occurs when a family leaves an assistance program due to increased income and then returns to the program within two calendar years.[32] Some degree of recidivism is expected; assistance programs exist to support families through financial hardship and, regardless of personal planning, unanticipated events can cause families to find themselves financially insecure following a period of relative financial stability. A high rate of recidivism, however, indicates that families are not exiting a program at a point where they are able to maintain self-sufficiency. Due to the structure of some public benefits programs, families may be exiting the program into financially tenuous situations and without a clear path for upward mobility.[33]

Program recidivism is exacerbated by factors like the benefits cliff, where families are exiting a program with fewer net resources, and persistent barriers to employment that were not sufficiently addressed before the family exited the program.

Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) system was established at the federal level in 1996 through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).[34] PRWORA ended the Aid to Families with Dependent Children (AFDC) program, a federal program which provided dedicated funding for direct cash assistance to needy families with children, and alternatively created the broad-purpose TANF block grant.[35] TANF became effective July 1, 1997, and was reauthorized by the Deficit Reduction Act of 2005.

The TANF block grant annually distributes federal funds to states, territories, and tribes to accomplish four federally defined purposes:[36]

- Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
- End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- Prevent and reduce the incidence of out-of-wedlock pregnancies; and
- Encourage the formation and maintenance of two-parent families.

TANF itself is not a single cohesive program; rather, it is a system of funding streams used at the state and local level to provide a wide range of benefits, services, and activities with the general aim of minimizing the effects, or addressing the root causes, of childhood economic disadvantage.[37] States use TANF funds to operate state-designed and state-administered programs with significant discretion in how the funds are used to achieve the statutory goals of TANF.[38] Most federal regulation of TANF-

[32] CareerSource Florida, Inc. *Temporary Assistance for Needy Families (TANF) Transitional Benefits Feasibility Study*. (2023). On file with the Health & Human Services Committee.
[33] Bourdeaux C. & Pandey, L. *Report on the Outcomes and Characteristics of TANF Leavers* (2017). Georgia State University, Center for State and Local Finance. Available at https://cslf.gsu.edu/download/outcomes-and-characteristics-of-tanf-leavers/?wpdmdl=6494571&refresh=5f7852f89a8bc1601721080 (last visited January 9, 2024).
[34] Center on Budget and Policy Priorities. *Policy Basics: Temporary Assistance for Needy Families* (2022). Available at https://www.cbpp.org/research/family-income-support/policy-basics-an-introduction-to-tanf#:~:text=States%20can%20use%20federal%20TANF,%2C%20and%20marriage%3B%20(3) (last visited February 13, 2024). *See also*, US Department of Health & Human Services, Office of Family Assistance. *Major Provisions of the Welfare Law* (1997). Available at https://www.acf.hhs.gov/ofa/policy-guidance/major-provisions-welfare-law (last visited February 13, 2024), for more information on PRWORA.
[35] Congressional Research Service. *Temporary Assistance for Needy Families: The Decline in Assistance Receipt Among Eligible Individuals* (2023). Available at https://crsreports.congress.gov/product/pdf/R/R47503 (last visited December 27, 2023).
[36] US Department of Health & Human Services. *About TANF* (2022). Available at https://www.acf.hhs.gov/ofa/programs/tanf/about (last visited December 27, 2023).
[37] Congressional Research Service. *The Temporary Assistance for Needy Families (TANF) Block Grant: A Primer on TANF Financing and Federal Requirements* (2023). Available at https://crsreports.congress.gov/product/pdf/RL/RL32748 (last visited December 27, 2023).
[38] *Supra*, note 36.

funded state programs relate to funding spent on direct cash assistance and the recipients of such assistance.[39]

TANF is funded through both federal and state dollars. The basic federal grant amount and minimum state contributions are set by law, based on expenditures in the pre-TANF programs in the early- to mid-1990s, and have not been adjusted for inflation. States are required to contribute non-federal "maintenance of effort" (MOE) funds based on state spending in the pre-TANF welfare programs. A state's required MOE contribution is lowered for states who have met the federal work participation standard for recipients of temporary cash assistance.[40]

Florida's Temporary Cash Assistance (TCA) Program

Direct cash assistance to needy families is the foundation of public welfare in the U.S.[41] Prior to the establishment of TANF in 1996, direct cash assistance to needy families through the AFDC program was the primary method of providing support to low-income families with children. Since the implementation of the TANF block grant system, the number of families receiving direct cash assistance has waned significantly, even among eligible populations, and the majority of TANF funds are allocated for indirect methods of assisting families.[42]

The Temporary Cash Assistance (TCA) program is Florida's direct cash assistance program for needy families. The TCA program is one of several Florida programs funded with the TANF block grant. Through the TCA program, families who meet specific technical, income, and asset requirements[43] may receive cash assistance in the form of monthly payments deposited into an electronic benefits transfer (EBT) account.[44]

The TCA program is administered by several state agencies through a series of contracts and memoranda of understanding. The Department of Children and Families (DCF) receives the federal TANF block grant funds, processes applications, determines initial eligibility, monitors ongoing eligibility, and disburses benefits to recipients. The Department of Commerce[45] (Florida Commerce) is responsible for financial and performance reporting to ensure compliance with federal and state measures and for providing training and technical assistance to Local Workforce Development Boards (LWDBs). LWDBs provide information about available jobs, on-the-job training, and education and training services within their respective areas and contract with one-stop career centers.[46] CareerSource Florida has planning and oversight responsibilities for all workforce-related programs and contracts with the LWDBs on a performance-basis.[47]

[39] *Supra*, note 37.
[40] *Supra*, note 37.
[41] Public cash assistance to needy families has its origin in the early 1900s; state and local entities financed "mother's pension" programs that provided support to single, often widowed, mothers so that children could be raised in their family homes rather than be institutionalized. *See*, Congressional Research Service, *The Temporary Assistance for Needy Families (TANF) Block Grant: A Legislative History* (2023). Available at https://crsreports.congress.gov/product/pdf/R/R44668 (last visited December 27, 2023).
[42] *Supra*, note 35.
[43] Children must be under the age of 18, or under age 19 if they are full time secondary school students. 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. *See*, Florida Department of Children and Families, *Temporary Cash Assistance (TCA)*. Available at https://www.myflfamilies.com/services/public-assistance/temporary-cash-assistance (last visited February 11, 2024).
[44] Florida Department of Children and Families. *Temporary Cash Assistance Fact Sheet* (2019). Available at https://www.myflfamilies.com/sites/default/files/2022-10/tcafactsheet_0.pdf (last visited February 11, 2024).
[45] The Department of Commerce, formerly known as the Department of Economic Opportunity, was renamed as such in the 2023 Legislative session. *See*, *Governor DeSantis Signs Legislation to Streamline Economic Development in Florida* (2023). Available at https://www.flgov.com/2023/05/31/governor-desantis-signs-legislation-to-streamline-economic-development-in-florida/ (last visited February 11, 2024).
[46] Florida Department of Commerce, CareerSource Florida, *Workforce Innovation and Opportunity Act Annual Statewide Performance Report* (2023). Available at https://careersourceflorida.com/wp-content/uploads/2023/12/2022-23-WIOA-Annual-Performance-Report.pdf (last visited February 12, 2024).
[47] *Id.*

The number of families receiving TCA dramatically increased during the COVID-19 pandemic, peaking at more than 50,000 families receiving TCA payments in July of 2020.[48] While TCA caseloads have not yet returned to pre-pandemic levels, they have decreased steadily since July of 2020. In November 2023, 34,015 families, including 44,309 children, received TCA.[49] Since 2016, Florida's recidivism rate for the TCA program has averaged 30 percent; approximately one third of families exiting TCA due to earned income were not successful in maintaining self-sufficiency and returned to the program within two years of exit.[50]

TCA Eligibility

States have broad discretion in determining who is eligible for cash assistance. Florida's TCA program requires applicants to meet all of the following criteria in order to be eligible:[51]

- Be a U.S. citizen or qualified noncitizen in accordance with federal and state law;
- Be a legal resident of Florida;
- Have a minor child residing with a custodial parent or relative caregiver, or be a pregnant woman in the 9th month of pregnancy;
- Have a gross income of 185 percent or less of the federal poverty level;[52]
- Have liquid or nonliquid resources, of all members of the family, valued at less than $2,000; and[53]
- Register for work with the LWDB, unless an applicant qualifies for an exemption.

In Florida, TCA eligible families fall into one of two case categories: work-eligible or child-only.[54] Work-eligible cases generally include adult or teenaged heads of household who are subject to work requirements and qualify for benefits based on the needs of the entire family so long as work requirements are met. Child-only cases make up roughly half of TCA cases and include households wherein there is no work-eligible adult, such as participants in the Relative Caregiver Program.[55] Child-only cases receive TCA benefits based only on the needs of the eligible child(ren) in the household, rather than the entire family. As of November 2023, there were 16,425 child-only TCA cases and 17,590 TCA cases including an adult.[56]
In addition to work requirements, families must meet Learnfare requirements. This requires children ages six to 18 to meet school attendance requirements, and requires the child's caregiver to participate in school conferences. Families will lose benefits for any child who is habitually truant from school or drops out of school unless there is a good cause for non-attendance or a hardship exemption from the school.[57]

Florida imposes a lifetime limit of 48 cumulative months wherein an adult may be eligible for and receive cash assistance. Current law outlines specific, limited circumstances under which a person may be exempt from the time limitation. LWDBs are required to interview and assess the employment

[48] Florida Department of Children and Families. *ESS Standard Reports: Caseload Report*. Available at https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-standard (last visited January 5, 2024)
[49] Florida Department of Children and Families. *ESS Standard Reports: Flash Points*. Available at https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-standard (last visited January 5, 2024).
[50] CareerSource Florida, *Temporary Assistance for Needy Families (TANF) Transitional Benefits Feasibility Study*. (2023). On file with the Health & Human Services Committee.
[51] Florida Department of Children and Families. *Temporary Assistance for Needy Families – State Plan Renewal, October 1, 2020 – September 30, 2023*. Available at https://www.myflfamilies.com/sites/default/files/2022-10/TANF-Plan.pdf (last visited January 5, 2024).
[52] Gross income cannot exceed 185% FPL, and a family's countable income cannot exceed the payment standard for the family size. There is a $90 deduction on earned income per individual. *See*, Florida Department of Children and Families, *Temporary Cash Assistance (TCA)*. Available at https://www.myflfamilies.com/services/public-assistance/temporary-cash-assistance (last visited January 22, 2024)
[53] Licensed vehicles with a combined value of not more than $8,500 are excluded if a family includes individuals subject to the work requirement, or if the vehicle is necessary to transport a disabled family member and the vehicle has been specially equipped to transport the disabled person. *See*, s. 414.075, F.S.
[54] S. 414.045, F.S.
[55] The Relative Caregiver Program provides financial assistance to relatives who are caring full-time for an eligible child as an alternative to the child being placed in foster care. See, Florida Department of Children and Families, *Temporary Cash Assistance (TCA).* Available at https://www.myflfamilies.com/services/public-assistance/temporary-cash-assistance (last visited January 5, 2024).
[56] *Supra*, note 49.
[57] *Supra*, note 44.

prospects and barriers of each participant who is within six months of reaching the 48-month time limit;[58] however, few families exit TCA due to the time limit. Most households receive TCA for fewer than six months.[59]

The maximum payment that families are eligible for is based upon family size, the family's income, and the amount of a family's shelter obligation.[60] Shelter obligation reflects a family's housing expenses, such as rent payments. A family's actual TCA payment will vary based on the household's "countable income," such that their actual payment will be less than the amounts shown below.[61] The minimum payment that may be made to a family is $10 per month; families eligible for TCA benefits under $10 per month will not receive a TCA payment, but are considered TCA recipients for other purposes including the determination of Medicaid eligibility.[62]

TCA Monthly Payment Maximums[63]

Family Size	Shelter Obligation $50.01 and up	Shelter Obligation $0.01-50.00	Shelter Obligation $0
	Max. Benefit Amount	Max. Benefit Amount	Max. Benefit Amount
1	$180	$153	$95
2	$241	$205	$158
3	$303	$258	$198
4	$364	$309	$254
5	$426	$362	$289
6	$487	$414	$346
7	$549	$467	$392
8	$610	$519	$438
Additional Person	+$62	+$52	+$48

TCA Work Requirement

To be eligible for full-family TCA, work-eligible adult family members must participate in work activities, unless they qualify for an exemption.[64] Individuals who fail to comply with the work requirements may be sanctioned.[65] TCA applicants who are determined by DCF to not be exempt from the work requirement are referred to Florida Commerce for work registration and intake processing. DCF does

[58] S. 414.105, F.S.
[59] CareerSource Florida, Inc. *Temporary Assistance for Needy Families (TANF) Transitional Benefits Feasibility Study* (2023). On file with the Health & Human Services Committee.
[60] S. 414.095(10)-(12), F.S.
[61] *Supra*, note 44.
[62] Rule 65A-4.220, F.A.C.
[63] *Supra*, note 44.
[64] S. 414.024, F.S. *See also*, S. 414.095(1), F.S. A person may be exempt from the work requirement if they receive benefits under the Supplemental Security Income Program or the Security Disability Program, is a single parent of a child under three months of age (parenting preparation activities may be alternatively required), is exempt from the TCA time limitation due to hardship, or not considered work-eligible under federal policy. *See also*, Florida Department of Children and Families. *Temporary Assistance for Needy Families – State Plan Renewal, October 1, 2020 – September 30, 2023*. Available at https://www.myflfamilies.com/sites/default/files/2022-10/TANF-Plan.pdf (last visited February 12, 2024).
[65] S. 414.065, F.S.

not disburse benefits until Florida Commerce, or the LWDB, if applicable, has confirmed that the participant has registered for and attended orientation.

Upon referral, the participant must undergo assessment by the LWDB staff. The assessment is intended to:[66]

- Identify barriers to employment and/or full participation in countable work activities;
- Identify the participant's skills that will translate into employment and training opportunities;
- Review the participant's work history; and
- Identify other employability issues that could help or hinder the participant's move toward employment.

Once the assessment is complete, the staff member and participant create an individual responsibility plan (IRP). The IRP must include the:[67]

- The participant's employment goal;
- The participant's assigned activities;
- The services provided by program partners, community agencies and the workforce system which the participant is being referred to;
- The number of hours the participant is expected to complete; and
- The expected completion dates or deadlines associated with particular activities.

If an individual cannot participate in assigned work activities due to a medical incapacity, the individual may be exempted from the activity for a specific period of time.[68] To be excused from the work activity requirements, the participant's medical incapacity must be verified by a physician, in accordance with the procedures established by DCF.[69]

Qualifying Work Activities

Pursuant to state and federal law, there are 12 distinct types of work activities which can be used to satisfy a TCA recipient's work requirement.[70] The 12 activities are categorized as either "core" or "supplemental" activities; such categorization impacts how the activity is counted toward a TCA recipient's work requirement.[71]

Work Activities	
"Core" Activities	**"Supplemental" Activities**
• Unsubsidized employment • Subsidized private-sector employment • Subsidized public-sector employment • Work experience • On-the-job training • Job search and job readiness assistance • Community service programs • Vocational educational training • Providing child care services to an individual participating in a community service program	• Job skills training directly related to employment • Education directly related to employment • Completion of a secondary school program

[66] *Supra*, note 51.
[67] *Id*.
[68] S. 414.065(4)(d), F.S.
[69] Rule 65A-4.206(2)-(3), F.A.C.
[70] 45 CFR § 261.30; S. 445.024(1), F.S.; *See also*, Florida Department of Children and Families, *Temporary Assistance for Needy Families (TANF) – An Overview of Program Requirements* (2016). Available at https://www.myflfamilies.com/sites/default/files/2022-10/TANF%20101%20final_1.pdf (last visited February 12, 2024).
[71] *Id*.

Each of the activities listed above are considers "work activities" and may count toward a TCA recipient's work participation requirement, federal policy limits the extent to which certain activities count toward the individual's work requirement. A TCA recipient's work participation requirement may be satisfied entirely by "core" activities, while "supplemental" activities may only count toward the requirement after a certain number of "core" activity hours have been completed.[72] Federal and state law further limits how the different work activities may count toward a person's work requirement based on the characteristics of the individual and the length of time in which the individual engages in the activity.[73]

The number of required work participation hours and the ratio of "core" to "supplemental" work activities is determined by the structure of the recipient family. The number of work-eligible adults and the age of children in the family impact the required work participation hours.[74] For example, education directly related to employment includes activities such as GED examination prep courses, but these activities only count toward the full work participation hours of parents under the age of 20. Once a parent is over 20 years of age, they can no longer count GED prep courses toward their total required work activity hours.[75]

Work Participation Requirements	
Family Composition	**Required Work Participation Hours**
Single parent with a child under age 6	20 hours weekly of "core" work activities
Single parent with a child over 6, or two-parent families where one parent is disabled	30 hours weekly with at least 20 hours of "core" work activities
Married teen or teen head of household under age 20	Maintains satisfactory attendance at secondary school or the equivalent, or participates in education related directly to employment for at least 20 hours weekly
Two-parent families who do not receive subsidized child care	35 hours weekly with at least 30 hours of "core" work activities, combined between both parents
Two-parent families who receive subsidized child care	55 hours weekly with at least 50 hours in "core" activities, combined between both parents

Sanctions for Noncompliance

TCA recipients who fail to comply with work requirements may be sanctioned by the LWDBs. Sanctions result in cash assistance being withheld for a specified period of time, the length of which increases with repeated lack of compliance.[76] The process for imposing sanctions involves coordination between agencies; the LWDB first becomes aware of the noncompliance, Florida Commerce tracks compliance and notifies recipients of possible adverse action, and DCF applies the sanctions.[77]

When a recipient fails to comply with a mandatory work activity, the LWDB records the non-compliance in Florida Commerce's tracking system and sends the recipient a notice of adverse action; the recipient then has 10 days to contact Florida Commerce to show good cause[78] for missing the requirement.[79]

[72] 45 CFR § 261.31.
[73] 45 CFR § 261.31; S. 445.024, F.S.; *See also*, Congressional Research Service. *Temporary Assistance for Needy Families (TANF): The Work Participation Standard and Engagement in Welfare-to-Work Activities* (2017). Available at https://crsreports.congress.gov/product/pdf/R/R44751 (last visited January 10, 2023).
[74] Florida Department of Children and Families, *Temporary Assistance for Needy Families (TANF) – An Overview of Program Requirements* (2016). Available at https://www.myflfamilies.com/sites/default/files/2022-10/TANF%20101%20final_1.pdf (last visited February 12, 2024).
[75] *Id*.
[76] S. 414.065, F.S.
[77] Office of Program Policy Analysis & Government Accountability (OPPAGA). *Mandatory Work Requirements for Recipients of the Food Assistance and Cash Assistance Programs* (2018). On file with the Health & Human Services Committee.
[78] *Id*. DCF captures limited information regarding good-cause for noncompliance in three categories: temporary illness, household emergency, and temporary transportation unavailable.
[79] *Id*. at 11, *see also* rule 65A-4.205(3), F.A.C.

During the 10-day period, the LWDB must make both oral and written attempts to contact the participant to:[80]

- Determine if the participant had good cause for failing to meet the work requirement;
- Refer to or provide services to the participant, if appropriate, to assist with the removal of barriers to participation;
- Counsel the participant on the consequences for failure to comply with work or alternative requirement plan activity requirements without good cause;
- Provide information on transitional benefits if the participant subsequently obtained employment; and
- Make sure the participant understands that compliance with work activity requirements[81] during the 10-day period will avoid the imposition of a sanction.

If the recipient complies within 10 days, the LWDB does not request a sanction. However, if the recipient does not show good cause to the LWDB and does not comply, the LWDB sends DCF a sanction request.[82] Once DCF receives the sanction request from the LWDB, it then sends the recipient a notice of intent to sanction.[83] If the recipient does not show good cause within 10 days, the recipient is sanctioned by DCF, who then notifies Florida Commerce.[84]

Current law considers the following circumstances as good cause for noncompliance with work participation requirements:[85]

- Unavailability of child care in certain circumstances;[86]
- Treatment or remediation of past effects of domestic violence;
- Medical incapacity;
- Outpatient mental health or substance abuse treatment;
- Medical incapacity relating to a pending decision for Supplemental Security Income or Social Security Disability Income;
- Caring for a disabled family member when the need for such has been verified and alternate care is not available.

DCF has the authority to establish by rule other situations that would constitute good cause for noncompliance with work participating requirements.[87]

Florida Commerce classifies reasons for sanctions for noncompliance in the following categories:[88]

- Failure to respond to a mandatory letter. [89] Typically, this is the letter recipients receive from Florida Commerce upon referral from the DCF requiring them to register with Florida Commerce.
- Failure to attend a work activity.
- Failure to turn in a timesheet.
- Failure to attend training.

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[80] Rule 65A-4.205(3), F.A.C.
[81] The LWDB designee must provide the participant with another work activity within the 10-day period if it is impossible for the participant to comply with the original assigned activity.
[82] *Supra,* note 77. DCF only receives a request for sanction and not the reasons for the sanction. S*ee also,* rule 65A-4.205(4), F.A.C.
[83] *Id*.
[84] *Id*., *see also,* rule 65A-4.205(4), F.A.C
[85] S. 414.065(4), F.S.
[86] Specifically, if the individual is a single parent caring for a child who has not attained 6 years of age, and the adult proves to the LWDB an inability to obtain needed child care for one or more of the following reasons, as defined in the Child Care and Deve lopment Fund State Plan required by 45 C.F.R. part 98: (1) the unavailability of appropriate child care within a reasonable distance from the individual's home or worksite; (2) the unavailability or unsuitability of informal child care by a relative or under other ar rangements; or (3) the unavailability of appropriate and affordable formal child care arrangements. *See*, S. 414.065(4)(a), F.S.
[87] S. 414.065(4)(g), F.S.
[88] *Supra*, note 77.
[89] *Id*. For work-eligible individuals with at least one sanction in Fiscal Year 2017, over half the sanctions were for failure to respond to a mandatory letter in 14 of 24 LWDBs.

- Failure to turn in necessary documentation.

Consequences of sanctions are as follows:[90]

- 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.

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.[91] If a previously sanctioned participant fully complies with work activity requirements for at least six months, then the participant can be reinstated as being in full compliance with program requirements and TCA payments can resume.[92]

Federal Work Participation Standard

The federal government sets a minimum work participation standard which states must meet as a part of the conditions of receiving TANF block grant funding. The work participation standard is intended to measure how a state is performing in engaging TANF recipients in work or work activities and reinforce the programmatic goal of transitioning families from welfare to work.[93] Federal law stipulates that 50 percent of all families and 90 percent of two-parent families must be engaged in work in order to meet the standard.[94] In practice, however, the minimum standard varies by state due to credits a state can earn by either reducing the state's TANF caseload or using more of the state's own funds toward TANF programming than is required.[95] For Fiscal Year 2022, Florida's adjusted standard was 12.3 percent for all families and 52.3 percent for two-parent families.[96] States may be subject to monetary penalties if the federal minimum work participation rates are not met, though the federal government may reduce or waive these penalties through negotiation with states.[97]

TANF Transitional Benefits

One of the express goals of the TANF program is to end family dependence on public benefits by promoting job preparation and work; this is foundational to the welfare-to-work concept on which the TANF program is based.[98] Most TCA recipients work both before and after leaving the program; however, they are predominantly employed in low-wage jobs with few opportunities for advancement.[99] TANF transitional benefits are intended to help families navigate this period when they become ineligible for TCA but are not yet fully self-sufficient.

[90] S. 414.065(1), F.S.
[91] S. 414.065(2), F.S.
[92] S. 414.065, F.S.
[93] Congressional Research Service. *Temporary Assistance for Needy Families (TANF): The Work Participation Standard and Engagement in Welfare-to-Work Activities* (2017). Available at https://crsreports.congress.gov/product/pdf/R/R44751 (last visited February 12, 2024).
[94] 45 CFR § 261.20
[95] *Supra*, note 93.
[96] US Department of Health & Human Services, Administration for Children and Families. *Temporary Assistance for Needy Families (TANF) and Separate State Programs Maintenance of Effort (SSP-MOE): Work Participation Rates and Engagement in Work Activities Fiscal Year 2022*. Available at https://www.acf.hhs.gov/sites/default/files/documents/ofa/wpr_FY2022_final-web.pdf (last visited February 13, 2024).
[97] 45 CFR § 261.50
[98] *Supra*, note 93.
[99] Safawi, A. & Pavetti, L. *Most Parents Leaving TANF Work, But in Low-Paying, Unstable Jobs, Recent Studies Find* (2020). Center on Budget and Policy Priorities. Available at https://www.cbpp.org/research/family-income-support/most-parents-leaving-tanf-work-but-in-low-paying-unstable-jobs (last visited January 9, 2024).

TCA recipients who become ineligible due to reasons other than noncompliance with work requirements, such as time limits or earned income, are eligible for transitional benefits intended to reduce the unintended negative effects of the lost benefits. Transitional benefits are designed to support work retention and advancement and assist individuals in achieving economic self-sufficiency.

Families generally become ineligible for TCA when their income reaches 185 percent of the federal poverty level (FPL), at which point they become eligible for transitional benefits.[100] Current law outlines four types of transitional benefits which are available to eligible former TCA recipients.

Transitional Benefits		
Benefit Type	**Description**	**Eligibility Requirements**
Transitional Child Care[101]	Provides subsidized child care vouchers to families	Available for up to 24 months, with an income cap of 200% FPL
Transitional Medical[102]	Allows families to remain eligible for Medicaid	Available for up to 12 months, with an income cap of 185% FPL after 6 months
Transitional Education and Training[103]	Job-related education and training	Available for up to 24 months, with an income cap of 200% FPL
Transitional Transportation[104]	Support typically provided to families in the form of payment for public transportation or gas	Available for up to 24 months, with an income cap of 200% FPL

CareerSource Florida administers transitional benefits through the LWDBs. The provision of transitional benefits depends on the LWDBs available resources and funding, as well as the availability of appropriate services locally.[105]

Supplemental Nutrition Assistance Program (SNAP)

Program Overview

The Food and Nutrition Service (FNS), under the U.S. Department of Agriculture (USDA), administers the Supplemental Nutrition Assistance Program (SNAP).[106] SNAP is the nation's largest domestic food and nutrition program for low-income Americans, offering nutritional assistance to millions of individuals and families each year through the provision of funds that can be used to purchase eligible foods.[107] In Fiscal Year 2020, SNAP provided assistance to approximately 39.9 million people living in 20.5 million households across the US.[108] SNAP benefits support individual households by reducing the effects of

[100] *See*, Florida Department of Children and Families, Temporary Cash Assistance (TCA). Available at https://www.myflfamilies.com/services/public-assistance/temporary-cash-assistance (last visited January 22, 2024). To be eligible, a family's gross income must be less than 185% FPL, and countable income cannot exceed the payment standard for the family size. There is a $90 deduction from each individual's gross earned income.
[101] S. 445.032, F.S.
[102] S. 445.029, F.S.
[103] S. 445.030, F.S.
[104] S. 445.031, F.S.
[105] CareerSource Florida, Inc. *Legislative Inquiry Response* (2024). On file with the Health & Human Services Committee.
[106] The Food Stamp Program (FSP) originated in 1939 as a pilot program for certain individuals to buy stamps equal to their normal food expenditures: for every $1 of orange stamps purchased, people received 50 cents worth of blue stamps, which could be used to buy surplus food. The FSP expanded nationwide in 1974. Under the federal welfare reform legislation of 1996, Congress enacted major changes to the FSP, including limiting eligibility for certain adults who did not meet work requirements. The Food and Nutrition Act of 2008 renamed the FSP the Supplemental Nutrition Assistance Program (SNAP) and implemented priorities to strengthen program integrity; simplify program administration; maintain states' flexibility in how they administer their programs; and improve access to SNAP. *See,* US Department of Agriculture, Food and Nutrition Service. *Short History of SNAP*. Available at https://www.fns.usda.gov/snap/short-history-snap (last visited February 12, 2024).
[107] US Department of Agriculture, Economic Research Service. *Supplemental Nutrition Assistance Program (SNAP) Overview*. Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap/ (last visited February 12, 2024).
[108] US Department of Agriculture, Food and Nutrition Service. *Characteristics of SNAP Households: FY 2020 and Early Months of the COVID-19 Pandemic: Characteristics of SNAP Households.* Available at https://www.fns.usda.gov/snap/characteristics-snap-households-fy-2020-and-early-months-covid-19-pandemic-characteristics (last visited February 12, 2024).

poverty and increasing food security while supporting economic activity across communities, as SNAP directly benefits farmers, retailers, food processors and distributors, and their employees.[109]

SNAP is a federal program administered in Florida by DCF.[110] DCF determines and monitors eligibility and disburses benefits to SNAP participants. The state and federal governments share the administrative costs of the program, while the federal government funds 100 percent of the benefit amount received by participants.[111] Federal laws, regulations, and waivers provide states with various policy options to better target benefits to those most in need, streamline program administration and field operations, and coordinate SNAP activities with those of other programs.[112]

The USDA developed the Thrifty Food Plan, a minimal cost food plan reflects current nutrition standards and guidance, the nutrient content and cost of food, and consumption patterns of low-income households to serve as the basis for the determination of SNAP benefits.[113] SNAP benefits are intended to supplement food purchases made with a household's own income; as such, the formula used to determine SNAP benefits assumes that a household will spend 30 percent of their net income on food purchases.[114] The benefit allotted to SNAP households is equal to the difference between the maximum allotment for their household size under the Thrifty Food Plan and 30 percent of their net income.[115] The structure of this formula ensures that the lowest income households receive the most benefits.

As of January 2023, 3,220,757 individuals, including 1,262,174 children and 1,017,860 elderly or disabled individuals, were receiving SNAP benefits in Florida.[116]

SNAP Eligibility & Work Requirements

To be eligible for SNAP, households must meet the following criteria: (1) gross monthly income must be at or below 130 percent of the poverty level; (2) net income must be equal to or less than the poverty level; and (3) assets must be below the limits set based on household composition.[117]

Individuals may be deemed ineligible for SNAP for any of the following:[118]

- Conviction for drug trafficking;
- Fleeing a felony warrant;
- Breaking SNAP or TANF program rules;
- Failure to cooperate with the child support enforcement agency; or
- Being a noncitizen without qualified status.

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[109] US Department of Agriculture, Economic Research Service. *Supplemental Nutrition Assistance Program (SNAP) Economic Linkages.* Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap/economic-linkages/ (last visited February 12, 2024).
[110] S. 414.31, F.S.
[111] Center on Budget and Policy Priorities. *Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)*. Available at https://www.cbpp.org/research/food-assistance/the-supplemental-nutrition-assistance-program-snap#:~:text=The%20federal%20government%20pays%20the,the%20states%2C%20which%20operate%20it. (last visited February 12, 2024).
[112] US Department of Agriculture, Food and Nutrition Service. *State Options Report* (2023). Available at https://www.fns.usda.gov/snap/waivers/state-options-report (last visited February 12, 2024).
[113] US Department of Agriculture, Food and Nutrition Service. *Nutrition Assistance Program Report: Barriers That Constrain the Adequacy of Supplemental Nutrition Assistance Program Allotments: Survey Findings* (2021). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-Barriers-SurveyFindings.pdf (last visited February 12, 2024).
[114] *Id.*
[115] *Id.*
[116] Email from Chad Corcoran, Deputy Director of Legislative Affairs, Department of Children and Families, *Re: SNAP Participants* (March 2, 2023). On file with the Health & Human Services Committee.
[117] US Department of Agriculture, *Indicators of Diet Quality, Nutrition, and Health for Americans by Program Participation Status, 2011-2016: SNAP Report. Final Report* (2021). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/Indicators-Diet-QualitySNAP.pdf (last visited January 16, 2024).
[118] Florida Department of Children and Families, *SNAP Eligibility.* Available at https://www.myflfamilies.com/services/public-assistance/supplemental-nutrition-assistance-program-snap/snap-eligibility (last visited January 16, 2024). *See also*, s. 414.32, F.S.

Able-bodied, non-elderly adults are generally required to participate in work activities in order to be eligible for SNAP. Federal policy outlines two tiers of work requirements for SNAP recipients: the general work requirement and the Able-Bodied Adult Without Dependents (ABAWD) work requirement.

The general work requirement applies to all recipients between 16 and 59 years of age, unless they qualify for an exemption.[119] The general work requirements include requiring a recipient register for work, participating in SNAP Employment and Training (E&T) or workfare if assigned, taking a suitable job if offered, and not voluntarily quitting a job or reducing work hours below 30 a week without a good reason.[120]

The ABAWD work requirement applies to adults between age 18 and 52, able-bodied, and without dependents (ABAWDs) are subject to the ABAWD work requirement, unless otherwise exempt.[121] ABAWDs are required to work or participate in a qualifying work program for a combined total of at least 80 hours per month. ABAWDs who fail to comply with the ABAWD work requirement for three months in a 36-month period lose their SNAP benefits.[122]

SNAP Mandatory Employment and Training

SNAP Employment and Training (SNAP E&T) is intended to help SNAP recipients gain skills, training, work, or experience that will help them obtain regular employment. States are required to operate a SNAP E&T program which includes case management and at least one of the following components:

- Supervised job search;
- Job search training;
- Workfare;
- Work experience;
- Education; or
- Self-employment.

Beyond the requirement that a state operate a SNAP E&T program including the minimum components, states have significant flexibility in how they design their SNAP E&T programs in order to meet the needs of SNAP participants and address local workforce needs.[123] The parameters of Florida's SNAP E&T program are established by DCF in the SNAP E&T State Plan[124] which must be approved by the federal government.[125]

[119] A person may be excused from the general work requirement if they are already working at least 30 hours per week, meeting the work requirements for another program, taking care of a child under 6 or an incapacitated person, unable to work due to a physical or mental limitation, participating regularly in an alcohol or drug treatment program, or studying in school or a training program at least half-time. *See*, US Department of Agriculture, Food and Nutrition Service. *SNAP Work Requirements*. Available at https://www.fns.usda.gov/snap/work-requirements (last visited January 10, 2024).
[120] US Department of Agriculture, Food and Nutrition Service. *SNAP Work Requirements*. Available at https://www.fns.usda.gov/snap/work-requirements (last visited January 10, 2024).
[121] *Id*. Adults who are unable to work due to a physical or mental limitation, are pregnant, have someone under 18 in their SNAP household, are excused from the general work requirement (*see also*, note 119), are a veteran, experiencing homelessness, or were in foster care on their 18th birthday and are under age 24 are exempt from the ABAWD requirements.
[122] US Department of Agriculture, Food and Nutrition Service. *Supplemental Nutrition Assistance Program (SNAP) ABAWD Policy Guide* (2023). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-ABAWD-Policy-Guide-September-2023.pdf (last visited February 14, 2024).
[123] *Supra*, note 122.
[124] *See*, Florida Department of Children and Families. *Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) State Plan – Federal Fiscal Year 2024* (2023). Available at https://www.floridajobs.org/docs/default-source/lwdb-resources/programs-and-resources/snap/florida-fy2024-snap-et-state-plan-final_10-31-2023.pdf?sfvrsn=96c95db0_2 (last visited January 16, 2024).
[125] 7 CFR § 273.7(c)(8).

Florida operates a mandatory SNAP E&T program for adults between the ages of 18 and 59[126] without dependents who are not exempt from the general or the ABAWD work requirements. SNAP E&T components that are available to mandatory E&T participants include supervised job search, job search training, work experience, education, vocational training, and job retention services. If DCF determines there is not an appropriate and available SNAP E&T component for an individual, the participant will be exempt from mandatory SNAP E&T participation.[127]

Currently, when the ABAWDs are determined eligible for benefits, DCF refers these clients to Florida Commerce and the CareerSource Florida network to engage in a comprehensive assessment to identify barriers to employment, training needs, and professional opportunities. Florida Commerce and CareerSource Florida utilize relationships with educational institutions, private sector employers and programs like apprenticeships to assist Floridians in achieving meaningful employment.[128]

DCF is required to reimburse SNAP E&T participants for all reasonable, allowable, and necessary expenses related to program participation. This may include but is not limited to childcare, tuition, books, and work uniforms. If DCF is unable to reimburse the participant, the individual must be exempted from mandatory participation in the SNAP E&T program.[129]

School Readiness Program

Program Overview

The School Readiness (SR) program is a state-federal partnership between Florida's Division of Early Learning (DEL) within the Florida Department of Education (DOE) and the Office of Child Care of the United States Department of Health and Human Services.[130] The SR program is administered by DEL at the state level and early learning coalitions (ELC) at the county and regional levels.[131] The DEL partners with 30 local ELCs and the Redlands Christian Migrant Association to deliver comprehensive early childhood care and education services statewide.[132] The SR Program is one of three main early learning programs overseen by DEL.[133]

Established in 1999[134], the SR program provides subsidies for child care services and early childhood education for children of low-income families; children in protective services who are at risk of abuse, neglect, abandonment, or homelessness; foster children; and children with disabilities.[135] The SR program offers financial assistance for child care to families while supporting children in the development of skills for success in school. Additionally, the program provides developmental screenings and referrals to health and education specialists where needed. These services are

[126] In 2024, Florida expanded the definition of mandatory E&T participants to include ABAWDs and work registrants between the ages of 18 and 59 who do not have children in the household. *See*, Florida Department of Children and Families, *Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) State Plan – Federal Fiscal Year 2024* (2023). Available at https://www.floridajobs.org/docs/default-source/lwdb-resources/programs-and-resources/snap/florida-fy2024-snap-et-state-plan-final_10-31-2023.pdf?sfvrsn=96c95db0_2 (last visited January 16, 2024).
[127] *Id.*
[128] Florida Department of Children and Families, *Economic Self-Sufficiency – SNAP Work Requirements Memo* (2023). On File with the Health & Human Services Committee.
[129] *Id*.
[130] U.S. Department of Health and Human Services. *Office of Child Care Fact Sheet*. Available at https://www.acf.hhs.gov/sites/default/files/documents/occ/factsheets_occ.pdf (last visited January 9, 2024).
[131] S. 1002.83, F.S.; *see also*, Florida Department of Education. *Division of Early Learning Annual Report 2022-2023*. Available at https://www.fldoe.org/core/fileparse.php/20628/urlt/2223-DEL-AnnualReport.pdf (last visited January 8, 2024).
[132] *Id*.
[133] The DEL also oversees the Voluntary Prekindergarten Program and the Child Care Resource & Referral Programs. *See also*, Florida Department of Education, Division of Early Learning. *Early Learning.* Available at http://www.floridaearlylearning.com/school-readiness (last visited January 9, 2024).
[134] Ch. 99-357, Laws of Fla., S. 1.
[135] Ss. 1002.81 and 1002.87, F.S.

provided in conjunction with other programs for young children such as Child Care Resource and Referral and the Voluntary Prekindergarten Program.[136]

The DCF Office of Child Care Regulation, as the regulatory agency over child care providers, inspects all child care providers that provide the SR services for compliance with specified health and safety standards.[137] In lieu of DCF regulation, counties may designate a local licensing agency to license providers if its licensing standards meet or exceed DCF's standards.[138] Five counties have done this – Broward, Hillsborough, Palm Beach, Pinellas, and Sarasota. In these five counties the local licensing agency, not DCF, inspects child care providers that provide the SR services for compliance with health and safety standards.[139]

School Readiness Program Funding

The SR Program is primarily funded through the federal Child Care and Development Fund (CCDF) Block Grant. The regulations governing the use of CCDF funds authorizes states to use grant funds for child care services if:[140]

- The child is under 13 years of age, or at the state's option, under age 19 if the child is physically or mentally incapable of caring for himself or herself or under court supervision;
- The child's family income does not exceed 85 percent of the state's median income (SMI) for a family of the same size; and
- The child:
    - resides with a parent or parents who work or attend job training or educational programs; or
    - receives, or needs to receive, protective services.

In addition to the CCDF Block Grant, the SR program receives additional funding through the Federal TANF Block Grant, Federal Social Services Block Grant, and the General Revenue Fund.[141]
The Legislature appropriates the SR program funds to the ELCs and the Redlands Christian Migrant Association, with participating providers receiving their funding primarily from reimbursements from the ELCs and tuition payments by enrolled families.[142] The ELCs reimburse participating providers with appropriated funds for each eligible child, either through child care certificates provided by parents or through contracted slots.[143] Provider reimbursement rates are based on provider type and the level of care a child receives with consideration of the market rate schedule set by the DOE.[144] The reimbursement rate schedules are set locally by the ELC and must be approved by the DEL.[145]

School Readiness Program Participation & Eligibility

There were 209,986 children enrolled with 6,790 providers in the SR program during the 2022-2023 fiscal year.[146]

Early learning coalitions are required by statute to prioritize the following groups for participation in the SR program:[147]

[136] Florida Department of Education, Division of Early Learning. *Early Learning.* Available at http://www.floridaearlylearning.com/school-readiness (last visited January 9, 2024).
[137] Ss. 402.306-402.319 and 1002.88, F.S.
[138] S. 402.306(1), F.S.
[139] See, Florida Department of Education. *Child Care Development Fund (CCDF) Plan for Florida: FFY 2022-2024*, p. 240. Available at https://www.fldoe.org/core/fileparse.php/20628/urlt/2022-2024-CCDF-State-Plan.pdf (last visited January 16, 2024).
[140] 45 C.F.R. § 98.20(a).
[141] Florida Department of Education. *Division of Early Learning Annual Report 2022-2023* (2023). Available at https://www.fldoe.org/core/fileparse.php/20628/urlt/2223-DEL-AnnualReport.pdf (last visited January 8, 2024).
[142] Sections 1002.84(9) and 1002.89, F.S.
[143] Rule 6M-4.500(1), F.A.C.
[144] Rule 6M-4.500(1), F.A.C.; *See also*, s. 1002.895, F.S.
[145] Rule 6M-4.500(1), F.A.C.
[146] *Supra*, note 141.
[147] Section 1002.87, F.S.

- Children younger than 13 with a parent receiving temporary cash assistance under ch. 414, F.S., and subject to the federal TANF work requirements or a parent who has an Intensive Service Account or an Individual Training Account under s. 445.009, F.S.; and
- At-risk children[148] younger than 9.

Subsequent enrollment in the program is determined according an assessment of local priorities within the ELC's region based on the needs of families and provider capacity using available community data.[149] Based on these local priorities, enrollment in the SR program can be made available to children meeting at least one of the following criteria:[150]

- Economically disadvantaged[151] children until eligible to enter kindergarten. Their older siblings up to the age they are eligible to enter 6th grade may also be served;
- Children from birth to kindergarten whose parents are transitioning from the TCA work program to employment;
- At-risk children who are at least age 9 but younger than 13;
- Economically disadvantaged children younger than 13;
- Children younger than 13 whose parents are transitioning from the TCA work program to employment;
- Children who have special needs and current individual educational plans from age 3 until they are eligible to enter kindergarten; and
- Children concurrently enrolled in the federal Head Start Program and VPK.

School Readiness Copayments and Fees

Parents of children enrolled in the SR program are responsible for paying a copayment directly to the child care provider. Rather than paying the full tuition amount of a child care provider, SR program copayments are intended to be set at a rate that eliminates cost as a barrier to services for families.[152] Copayments are based on a sliding fee scale set by the ELC and approved by the DEL.[153] An ELC's sliding fee scale must be set such that economically disadvantaged families have equal access to the care available to families whose income makes them ineligible for school readiness services.[154] Parent copayments may not exceed 10 percent of a family's income unless the ELC provides justification of how the sliding fee scale meets the federal requirement that the copayment be affordable. In addition to the copayment, families may be subject to additional fees, such as a registration fee. The ELC may pay for a participant's registration fees up to $75 in certain circumstances.[155]

The current copay schedule is not established with a smooth transition to the market rate for child care at the end of the eligibility threshold. Instead, copays tend to remain relatively low as family income increases, but when a family's income reaches the eligibility threshold of 85 percent state median income (SMI), families lose the SR program benefit and are suddenly subject to the full cost of child care. This transition creates a significant benefit cliff for families participating in the SR program if their income level upon exiting the program is insufficient to afford the full cost of child care. In some cases,

[148] "At-risk child" is defined under s. 1002.81, F.S., as a child meeting one of the following criteria: from a family under investigation or supervision by the Department of Children and Families (DCF) or a designated sheriff's office for child abuse, neglect, aband onment, or exploitation; in a diversion program provided by DCF or its contracted provider and who is from a family that is actively participating and complying in department-prescribed activities, including education, health services, or work; placed in court-ordered, long-term custody or under the guardianship of a relative or nonrelative after termination of supervision by DCF or its contracted provider; in the custody of a parent who is considered a victim of domestic violence and is receiving services through a certified domestic violence center; in the custody of a parent who is considered homeless as verified by a DCF certified homeless shelter.
[149] S. 1002.85(2)(i), F.S.
[150] S. 1002.87(1), F.S.
[151] "Economically disadvantaged" is defined under s. 1002.81, F.S., as having a family income that does not exceed 150 percent of the federal poverty level and includes being a child of a working migratory family as defined by 34 C.F.R. s. 200.81(d) or (f) or an agricultural worker who is employed by more than one agricultural employer during the course of a year, and whose income varies according to weather conditions and market stability.
[152] S. 1002.84(9), F.S.
[153] Rule 6M-4.400, F.A.C.
[154] Rule 6M-4.400, F.A.C.
[155] Rule 6M-4.500, F.A.C.

families may attempt to "park" their income below the eligibility threshold in order to not lose access to the child care benefit.[156]

Career Ladder Identifier and Financial Forecaster (CLIFF)

The Career Ladder Identifier and Financial Forecaster (CLIFF) navigator is a suite of tools developed by the Federal Reserve Bank of Atlanta to model the interaction of public benefits, taxes, and tax credits with career advancement. The tool is used to help working families navigate the complex system of public assistance, stabilize their financial situation in the short term, and plan long-term career paths.[157]

CareerSource Florida partnered with the Federal Reserve Bank of Atlanta to incorporate the CLIFF suite of tools into state workforce programs. A Florida-specific suite of CLIFF tools has been developed and is being introduced into the LWDB's processes, and staff at both CareerSource Florida and DCF have received training on the suite of CLIFF tools. The goal of this program is to assist Floridians in identifying career strategies and achieving economic stability while minimizing the negative impacts of losing public assistance.[158]

Effect of the Bill

Temporary Assistance for Needy Families (TANF)

Qualifying Work Activities

CS/CS/HB 1267 allows adults who have not attained a high school diploma, or its equivalent, to satisfy their TCA work activity requirement through participating in adult basic education or high school equivalency examination preparation for at least 20 hours per week.

Under federal law, adult basic education and high school equivalency examination preparation are considered "supplemental" activities that do not satisfy the work requirements of most TCA recipients.[159] As a result, depending on the uptake among TCA recipients, this provision could have a negative impact on the state's work participation rate (WPR), which in turn could subject the program to federal penalties.[160] To mitigate this risk while encouraging high school completion, the bill includes a mechanism by which this provision may be suspended if the state's WPR falls below the federally required minimum rate. If the state's WPR does not exceed the federal minimum WPR by more than 10 percent, then Florida Commerce must suspend the provision until the state has exceeded the federal minimum WPR by 10 percent for three consecutive months. If the provision is suspended, Florida Commerce issues notice to the affected TCA recipients within five days of the policy's suspension.

Under the bill, if the provision allowing adult basic education or high school equivalency examination preparation as a work activity is suspended, individuals whose work requirements are impacted are protected from being sanctioned as a result of the state's action: impacted TCA recipients are considered to have good cause for noncompliance for up to six weeks after the change in the participants' work requirements.

Transitional Case Management

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[156] *Supra*, note 12.
[157] Federal Reserve Bank of Atlanta. *Career Ladder Identifier and Financial Forecaster (CLIFF)*. Available at https://www.atlantafed.org/economic-mobility-and-resilience/advancing-careers-for-low-income-families/cliff-tool (last visited January 19, 2024).
[158] CareerSource Florida, Inc. *2022-2023 Annual Report* (2023). Available at https://careersourceflorida.com/wp-content/uploads/2023/12/CAREERSOURCE-FLORIDA-FY-22-23-ANNUAL-REPORT_DIGITAL.pdf (last visited January 19, 2024).
[159] 45 CFR § 261.30; S. 445.024(1), F.S.; *See also*, Florida Department of Children and Families, *Temporary Assistance for Needy Families (TANF) – An Overview of Program Requirements* (2016). Available at https://www.myflfamilies.com/sites/default/files/2022-10/TANF%20101%20final_1.pdf (last visited February 12, 2024).
[160]

The bill creates transitional case management as a transitional benefit available to families who have transitioned off of cash assistance, in order to provide additional, voluntary support to families as they pursue long-term financial independence. Under the bill, TCA recipients who have been determined ineligible for cash assistance for a reason other than noncompliance with work activity requirements are eligible for voluntary case management services administered by the LWDB. Case management services must include career planning, job search assistance, resume building, basic financial planning, connection to support services, and benefit management using the CLIFF Navigator tool.

The bill directs Florida Commerce to develop training for the LWDBs relating to case management methods and the provision of welfare transition services generally.

Data Collection

The bill directs CareerSource Florida, in collaboration with Florida Commerce and DCF, to develop standardized surveys for TCA recipients to be administered by the LWDBs. The bill requires CareerSource Florida to develop an intake survey to collect baseline information as a person is entering the program, and an exit survey to collect information which can be used to discern programmatic impacts on individuals over time. The purpose of the surveys is to monitor program effectiveness, inform program improvements, and effectively allocate resources.

The bill requires that the intake surveys collect, at a minimum, information relating to perceived barriers to employment, reasons for past separation from employment, stated goals for employment or professional development, the highest level of education or training the individual has attained, and awareness of non-cash assistance transitional services. The bill directs the LWDBs to administer the intake survey in conjunction with the diversion screening process required under s. 445.017, F.S., or in case of administrative oversight, the bill generally requires the survey be completed by each new TCA recipient who has not otherwise completed the survey.

The bill requires that the exit surveys collect, at a minimum, information on the TCA recipient's enrollment in other benefits programs, long-term career plan, credentials, education, or training received during enrollment, barriers to employment addressed, and remaining barriers to employment. The bill directs the LWDBs to administer the exit survey at the points of contact required in current law[161] when a TCA recipient becomes, or is anticipated to become, ineligible for TCA.

The bill directs the LWDBs to submit the completed surveys to CareerSource Florida and disseminate anonymized data to Florida Commerce and DCF on a quarterly basis. The bill requires Florida Commerce, in consultation with CareerSource Florida and DCF, to prepare and submit a report to the Legislature annually. The report is required to include survey results, an analysis of the barriers to employment faced by survey respondents, and recommendations for legislative and administrative changes to mitigate such barriers and improve the effective use of transitional benefits.

Supplemental Nutritional Assistance Program (SNAP)

The bill directs DCF, unless prohibited by the federal government, to require participation in SNAP E&T among SNAP recipients who:

- Are eligible for the program;
- Are between 18 and 59 years of age;
- Do not have children under age 18 in the home; and
- Do not otherwise meet an exemption.

[161] S. 414.105, F.S., requires TCA recipients to be interviewed when they near the 48-month lifetime limit on TCA.; s. 445.028, F.S., requires TCA recipients be contacted when they are determined ineligible for cash assistance.

This provision is consistent with Florida's most recent SNAP E&T State Plan which has been approved by the federal government.[162]

As Florida's designated state agency[163] for administering SNAP, DCF has significant discretion in determining which groups are subject to mandatory SNAP E&T participation, within federal guidelines.[164] Under current law, Florida has not restricted this discretion. By codifying this requirement, the bill prevents DCF from implementing future discretionary changes to limit the population required to participate in SNAP E&T, unless such changes are authorized by the Legislature or otherwise prohibited by the federal government.

Career Ladder Identifier and Financial Forecaster (CLIFF)

The bill requires the use of a tool to demonstrate future financial impacts (tool) relating to a person's change in income and benefits in several settings to provide additional guidance to recipients of public benefits. The CLIFF suite of tools developed with the Federal Reserve Bank of Atlanta is currently available for this purpose.

The bill requires the LWDB staff use the tool when interviewing TCA recipients who are approaching the 48-month lifetime limit for TCA. The bill also requires LWDB case managers use the tool when providing transitional case management services to individuals transitioning off of TCA. By requiring the tool be used in these settings, the bill ensures that current and former TCA recipients are receiving evidence-based information and guidance regarding their financial prospects and public benefits as they progress toward economic self-sufficiency.

The bill requires Florida Commerce to integrate the tool into the workforce service delivery system, and requires Florida Commerce to develop training for the LWDBs, and other workforce system partners, on the use of the tool. The bill also directs the ELCs to provide School Readiness Subsidy Program participants access to the tool.

School Readiness Subsidy Program

The bill creates the School Readiness Subsidy Program (subsidy program) within the DOE. The subsidy program will supplement the existing SR program and serve to mitigate the benefit cliff experienced by families as they become ineligible for the SR program funding due to earned income.

The subsidy program will be available to families who have become ineligible for the existing SR program due to family income and the family income is between 85 and 100 percent SMI. This applies to families who entered the existing SR program as "economically disadvantaged," with an income less than 150 percent FPL, and become ineligible when their income exceeds 85 percent SMI. SMI and FPL are based on family size; for example, for a family of three 150 percent FPL is $38,730, 85 percent SMI is $63,471, and 100 percent SMI is $74,672.

To receive a subsidy under the program, a parent must:

- Submit an application to the ELC in the form prescribed by the DOE;
- Provide any documentation necessary to verify eligibility for the subsidy; and
- Be responsible for the payment of child care expenses in excess of the amount of the subsidy.

[162] *See*, Florida Department of Children and Families. *Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) State Plan – Federal Fiscal Year 2024* (2023). Available at https://www.floridajobs.org/docs/default-source/lwdb-resources/programs-and-resources/snap/florida-fy2024-snap-et-state-plan-final_10-31-2023.pdf?sfvrsn=96c95db0_2 (last visited February 14, 2024). The State Plan was submitted on August 15, 2023.
[163] 7 CFR § 272.2
[164] *See*, US Department of Agriculture, Food and Nutrition Service. *Supplemental Nutrition Assistance Program (SNAP) ABAWD Policy Guide* (2023). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-ABAWD-Policy-Guide-September-2023.pdf (last visited January 10, 2024).

The subsidy program is available on a first-come, first-served basis, subject to a legislative appropriation.

The bill directs the ELCs to administer the subsidy program. The ELCs are responsible for determining the subsidy amount as a percentage of the ELC's approved provider reimbursement rates, with consideration of family income and a required parent copayment that increases in relation to family income. The amount of the subsidy and the parent copayment must be sufficient to allow the family to access child care providers and enable the parent to achieve self-sufficiency.

The bill provides a sum of $23,076,259 in nonrecurring funds from the General Revenue Fund to the DOE to implement the subsidy program for Fiscal Year 2024-2025.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 414.065, F.S., relating to noncompliance with work requirements.
Section 2: Amends s. 414.105, F.S., relating to time limitations of temporary cash assistance.
Section 3: Amends s. 414.455, F.S., relating to Supplemental Nutrition Assistance Program; legislative authorization.
Section 4: Amends s. 445.009, F.S., relating to one-stop delivery system.
Section 5: Amends s. 445.011, F.S., relating to consumer-first workforce system.
Section 6: Amends s. 445.017, F.S., relating to diversion.
Section 7: Amends s. 445.024, F.S., relating to work requirements.
Section 8: Amends s. 445.028, F.S., relating to transitional benefits and services.
Section 9: Creates s. 445.0281, F.S., relating to transitional case management.
Section 10: Amends s. 445.035, F.S., relating to data collection and reporting.
Section 11: Creates s. 1002.935, F.S., relating to School Readiness Subsidy Program.
Section 12: Provides an appropriation.
Section 13: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Data Collection and Reporting

CareerSource Florida, in collaboration with the departments of Commerce and Children and Families, shall develop standardized intake and exit surveys to collect and aggregate data to monitor program effectiveness. Any costs associated with this workload can be absorbed within existing resources of these three entities collectively.

There remains an indeterminate fiscal impact with regard to data storage and its dissemination to the DCF. To the degree that CareerSource does not have resources to house the information collected and share it with the DCF, and once workload is actually determined, CareerSource may submit a future budget request to the Legislature which details any such information technology infrastructure needs for consideration.

The workload associated with the annual reporting requirement provisions in the bill can be absorbed within existing Department of Commerce resources.

New School Readiness Subsidy Program

The bill provides the sum of $23,076,259 in nonrecurring funds from the General Revenue Fund for Fiscal Year 2024-2025 to the DOE to implement the School Readiness Subsidy Program. The DOE may incur costs if their current information technology system needs to be modified to administer the new subsidy program. The impact of this is indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Families who are able to receive the subsidy will have increased household resources. These resources may enable them to increase the hours they work, further benefitting those households economically.

Child care providers may experience increased enrollment from the expanded eligibility criteria allowing children to remain eligible for services.

D. FISCAL COMMENTS:

Depending on the degree to which former TCA recipients use the new transitional case management services, LWDBs may experience a workload increase from providing that service. The fiscal impact is indeterminate at this time.

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:

Sufficient rule-making authority is provided by the bill and exists in current law to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 24, 2024, the Children, Families & Seniors Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Aligned the provision of the bill relating to SNAP E&T with current, federally-approved DCF policy which does not require mandatory participation in SNAP E&T for households that include children under age 18; and
- Revised the provision of the bill relating to the SR program such that:
    - A new program is created to supplement the existing SR program;
    - The exit point of the supplemental program is established at 100 percent SMI;
    - The supplemental program is available on a first-come, first-served basis, subject to a legislative appropriation.

On February 8, 2024, the Appropriations Committee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Provided an appropriation in the sum of $23,076,259 in nonrecurring funds from the General Revenue Fund to the DOE to implement the School Readiness Subsidy Program established in s. 1002.935, F.S. The funds are placed in reserve and the DOE is authorized pursuant to chapter 216, F.S., to submit budget amendments requesting the release of the funds. The release is contingent upon the submission of an allocation plan developed by the DOE in collaboration with the early learning coalitions established in s. 1002.83, F.S.

The analysis is drafted to the committee substitute as approved by the Appropriations Committee.

A bill to be entitled

An act relating to economic self-sufficiency; amending s. 414.065, F.S.; providing that a participant has good cause for noncompliance with work requirements for a specified time period under certain circumstances; amending s. 414.105, F.S.; providing requirements for staff members of local workforce development boards when interviewing participants; amending s. 414.455, F.S.; requiring certain persons to participate in an employment and training program; amending s. 445.009, F.S.; requiring benefit management and career planning using a specified tool as part of the state's one-stop delivery system; amending s. 445.011, F.S.; requiring the Department of Commerce to develop certain training; conforming provisions to changes made by the act; amending s. 445.017, F.S.; requiring a local workforce development board to administer an intake survey; amending s. 445.024, F.S.; authorizing certain participants to participate in certain programs or courses for a specified number of hours per week; authorizing the Department of Commerce to suspend certain work requirements under certain circumstances; requiring the department to issue notice to participants under certain circumstances; amending s. 445.028, F.S.;

requiring the Department of Children and Families to administer an exit survey; creating s. 445.0281, F.S.; providing voluntary case management services to certain persons for specified purposes; providing requirements for such case management services and case managers; amending s. 445.035, F.S.; requiring CareerSource Florida, Inc., in collaboration with other entities, to develop standardized intake and exit surveys for specified purposes; specifying when such surveys must be administered; providing requirements for such surveys; requiring completed surveys to be submitted to CareerSource Florida, Inc., and disseminated quarterly to certain departments; requiring the Department of Commerce, in consultation with other entities, to prepare and submit an annual report to the Legislature; providing requirements for such report; creating s. 1002.935, F.S.; creating the School Readiness Subsidy Program within the Department of Education; providing requirements for the program; providing eligibility requirements to receive a subsidy under the program; requiring early learning coalitions to administer the program and provide participants access to a specified tool; providing for the calculation of the amount of the subsidy; providing requirements for parents to receive a

subsidy; providing an appropriation; providing an effective date.

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

Section 1. Subsection (1) of section 414.065, Florida Statutes, is 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. Before ~~Prior to~~ the imposition of a sanction, the participant must ~~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 must ~~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 requirements of s. 445.024(2)(a)1. are suspended pursuant to s. 445.024(2)(a)2., a participant in noncompliance because of such suspension is considered to have good cause for noncompliance for up to 6 weeks after the change in the participant's work requirements. If the participant has subsequently obtained employment, the participant must ~~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 is ~~shall be~~ terminated for the family for a minimum of 10 days or until the individual who failed to comply does so.

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

3. Third noncompliance: temporary cash assistance is ~~shall be~~ terminated for the family for 3 months or until the individual who failed to comply does so, whichever is later. The individual must ~~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 must ~~shall~~ be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

(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.

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

Section 2. Subsection (10) of section 414.105, Florida Statutes, is amended to read:

414.105 Time limitations of temporary cash assistance.—Except as otherwise provided in this section, an applicant or current participant shall receive temporary cash assistance for no more than a lifetime cumulative total of 48 months, unless otherwise provided by law.

(10) A member of the staff of the local workforce development board shall interview and assess the employment prospects and barriers of each participant who is within 6 months of reaching the 48-month time limit. The staff member

shall do all of the following:

(a) Administer the exit survey required under s. 445.035.

(b) Use a tool to demonstrate future financial impacts of the participant's change in income and benefits over time.

(c) Assist the participant in identifying actions necessary to become employed before reaching the benefit time limit for temporary cash assistance.

(d) ~~and,~~ If appropriate, ~~shall~~ refer the participant for services that could facilitate employment, including, but not limited to, transitional benefits and services.

Section 3. Section 414.455, Florida Statutes, is amended to read:

414.455 Supplemental Nutrition Assistance Program; legislative authorization; mandatory participation in employment and training programs.—

(1) Notwithstanding s. 414.45, and unless expressly required by federal law, the department must ~~shall~~ obtain specific authorization from the Legislature before seeking, applying for, accepting, or renewing any waiver of work requirements established by the Supplemental Nutrition Assistance Program under 7 U.S.C. s. 2015(o).

(2) Unless prohibited by the Federal Government, the department must require a person who is receiving food assistance; who is 18 to 59 years of age, inclusive; who does not have children under the age of 18 in his or her home; who

does not qualify for an exemption; and who is determined by the department to be eligible, to participate in an employment and training program.

Section 4. Paragraph (k) of subsection (1) of section 445.009, Florida Statutes, is redesignated as paragraph (l), and a new paragraph (k) is added to that subsection, to read:

445.009 One-stop delivery system.—

(1) The one-stop delivery system is the state's primary customer-service strategy for offering every Floridian access, through service sites or telephone or computer networks, to the following services:

(k) Benefit management and career planning using a tool to demonstrate future financial impacts of the participant's change in income and benefits over time.

Section 5. Subsections (1) and (5) of section 445.011, Florida Statutes, are amended to read:

445.011 Consumer-first workforce system.—

(1) The department, in consultation with the state board, the Department of Education, and the Department of Children and Families, shall implement, subject to legislative appropriation, an automated consumer-first workforce system that improves coordination among required one-stop partners and is necessary for the efficient and effective operation and management of the workforce development system. This system must ~~shall~~ include, but is ~~need~~ not ~~be~~ limited to, the following:

(a) An integrated management system for the one-stop service delivery system, which includes, at a minimum, common registration and intake for required one-stop partners, screening for needs and benefits, benefit management and career planning using a tool to demonstrate future financial impacts of the participant's change in income and benefits over time, case management, training benefits management, service and training provider management, performance reporting, executive information and reporting, and customer-satisfaction tracking and reporting.

1. The system should report current budgeting, expenditure, and performance information for assessing performance related to outcomes, service delivery, and financial administration for workforce programs pursuant to s. 445.004(5) and (9).

2. The system should include auditable systems and controls to ensure financial integrity and valid and reliable performance information.

3. The system should support service integration and case management across programs and agencies by providing for case tracking for participants in workforce programs, participants who receive benefits pursuant to public assistance programs under chapter 414, and participants in welfare transition programs under this chapter.

(b) An automated job-matching information system that is

accessible to employers, job seekers, and other users via the Internet, and that includes, at a minimum, all of the following:

1. Skill match information, including skill gap analysis; resume creation; job order creation; skill tests; job search by area, employer type, and employer name; and training provider linkage.~~;~~

2. Job market information based on surveys, including local, state, regional, national, and international occupational and job availability information.~~; and~~

3. Service provider information, including education and training providers, child care facilities and related information, health and social service agencies, and other providers of services that would be useful to job seekers.

(5) The department shall develop training for required one-stop partners on the use of the consumer-first workforce system, best practices for the use of a tool demonstrating future financial impacts of the participant's change in income and benefits over time, the different case management methods, the availability of welfare transition services, and how to prequalify individuals for workforce programs.

Section 6. Subsection (4) of section 445.017, Florida Statutes, is amended to read:

445.017 Diversion.—

(4)(a) The local workforce development board shall screen each family on a case-by-case basis for barriers to obtaining or

retaining employment. The screening must ~~shall~~ identify barriers that, if corrected, may prevent the family from receiving temporary cash assistance on a regular basis. At the time of screening, the local workforce development board shall administer the intake survey required under s. 445.035(2).

(b) Assistance to overcome a barrier to employment is not limited to cash, but may include vouchers or other in-kind benefits.

Section 7. Subsection (2) of section 445.024, Florida Statutes, is amended to read:

445.024 Work requirements.—

(2) WORK ACTIVITY REQUIREMENTS.—Each individual who is not otherwise exempt from work activity requirements must participate in a work activity for the maximum number of hours allowable under federal law; however, a participant may not be required to work more than 40 hours per week. The maximum number of hours each month that a family may be required to participate in community service or work experience programs is the number of hours that would result from dividing the family's monthly amount for temporary cash assistance and food assistance by the applicable minimum wage. However, the maximum hours required per week for community service or work experience may not exceed 40 hours.

(a)1. A participant who has not earned a high school diploma or its equivalent may participate in adult general

education, as defined in s. 1004.02(3), or a high school equivalency examination preparation, as defined in s. 1004.02(16). A participant must participate in such program or course for at least 20 hours per week in order to satisfy the participant's work activity requirement.

2. If the state's TANF work participation rate, as provided by federal law, does not exceed the federal minimum work participation rate by 10 percentage points in any month, the requirements of this subsection may be suspended by the department until the work participation rate exceeds the federal minimum work participation rate by 10 percentage points for at least 3 consecutive months.

3. If the requirements of this subsection are suspended, the department must issue notice to the affected participants of the changed work requirements within 5 days after the change in such work requirements.

(b) ~~(a)~~ A participant in a work activity may also be required to enroll in and attend a course of instruction designed to increase literacy skills to a level necessary for obtaining or retaining employment if the instruction plus the work activity does not require more than 40 hours per week.

(c) ~~(b)~~ Program funds may be used, as available, to support the efforts of a participant who meets the work activity requirements and who wishes to enroll in or continue enrollment in an adult general education program or other training

programs.

Section 8. Subsections (1) and (2) of section 445.028, Florida Statutes, are amended to read:

445.028 Transitional benefits and services.—In cooperation with the department, the Department of Children and Families shall develop procedures to ensure that families leaving the temporary cash assistance program receive transitional benefits and services that will assist the family in moving toward self-sufficiency. At a minimum, such procedures must include, but are not limited to, the following:

(1) Each recipient of cash assistance who is determined ineligible for cash assistance for a reason other than a work activity sanction must ~~shall~~ be contacted by the workforce system case manager and provided information about the availability of transitional benefits and services. Such contact must include the administration of the exit survey required under s. 445.035(2) and ~~shall~~ be attempted before ~~prior to~~ closure of the case management file.

(2) Each recipient of temporary cash assistance who is determined ineligible for cash assistance due to noncompliance with the work activity requirements must ~~shall~~ be contacted and provided information in accordance with s. 414.065(1). Such contact must include the administration of the exit survey required under s. 445.035(2).

Section 9. Section 445.0281, Florida Statutes, is created

to read:

445.0281 Transitional case management.—Each recipient of cash assistance who is determined ineligible for cash assistance for a reason other than noncompliance with work activity requirements is eligible for voluntary case management services administered by the local workforce development board. Case management services must be available to support families who transition to economic self-sufficiency and to mitigate dependency on cash assistance. Case management services must include, but are not limited to, career planning, job search assistance, resume building, basic financial planning, connection to support services, and benefits management using a tool to demonstrate future financial impacts of the participant's change in income and benefits over time, as applicable. Case managers must connect recipients to other transitional benefits as needed.

Section 10. Section 445.035, Florida Statutes, is amended to read:

445.035 Data collection and reporting.—

(1) The Department of Children and Families and the state board shall collect data necessary to administer this chapter and make the reports required under federal law to the United States Department of Health and Human Services and the United States Department of Agriculture.

(2) CareerSource Florida, Inc., in collaboration with the

department, the Department of Children and Families, and the local workforce development boards, shall develop standardized intake and exit surveys for the purpose of collecting and aggregating data to monitor program effectiveness, inform program improvements, and allocate resources.

(a) The intake survey must be administered by the local workforce development boards during the required diversion screening process under s. 445.017. The intake survey must be administered to each new recipient of temporary cash assistance under chapter 414 who has not otherwise completed the survey.

(b) The intake survey must, at a minimum, collect qualitative or quantitative data, as applicable, relating to all of the following:

1. The recipient's perceived individual barriers to employment.

2. The reasons cited by the recipient for his or her separation from employment in the previous 12 months.

3. The recipient's stated goals for employment or professional development.

4. The recipient's highest level of education or credentials attained or training received at the time of enrollment.

5. The recipient's awareness of welfare transition services.

(c) The exit survey must be administered by the local

workforce development boards to recipients of temporary cash assistance under chapter 414 as recipients prepare to transition off of temporary cash assistance. Based on a recipient's circumstances, the exit survey must be administered to the recipient at one of the following points of contact:

1. The recipient is approaching the statutory time limitation for temporary cash assistance and is interviewed pursuant to s. 414.105(10); or

2. At such time when the recipient becomes ineligible for cash assistance and is contacted pursuant to s. 445.028.

(d) The exit survey must, at a minimum, collect data relating to all of the following:

1. The recipient's enrollment in other public benefits programs at the time of exit.

2. Whether the recipient has a long-term career plan.

3. The recipient's credentials or education attained or training received during enrollment.

4. Barriers to the recipient's employment which were addressed during enrollment.

5. Any remaining barriers to the recipient's employment.

(e) The completed surveys must be submitted to CareerSource Florida, Inc., and anonymized data must be disseminated quarterly to the department and the Department of Children and Families.

(f) The department, in consultation with CareerSource

Florida, Inc., and the Department of Children and Families, shall prepare and submit to the President of the Senate and the Speaker of the House of Representatives a report by January 1 of each year. The report must include, at a minimum, the results of the intake and exit surveys, an analysis of the barriers to employment experienced by the survey respondents, and any recommendations for legislative and administrative changes to mitigate such barriers and improve the effective use of transitional benefits.

Section 11. Section 1002.935, Florida Statutes, is created to read:

1002.935 School Readiness Subsidy Program.—The School Readiness Subsidy Program is created within the Department of Education to support the continued school readiness and child care needs of working families with children. The program is contingent upon a legislative appropriation and is provided on a first-come, first-served basis.

(1)(a) A child who is determined to be ineligible for school readiness program funds due to family income during the annual eligibility determination pursuant to s. 1002.87(6) is eligible for a subsidy under this section if the family income is between 85 percent and 100 percent, inclusive, of the state median income.

(b) The early learning coalitions established in s. 1002.83 shall administer the School Readiness Subsidy Program

and provide participants with access to the benefit management and career planning tool described in s. 445.009(1)(k).

(2)(a) The amount of the subsidy is a percentage of the early learning coalition's approved school readiness program provider reimbursement rates as calculated pursuant to s. 1002.84(17). An early learning coalition shall consider family income and a required parent copayment that increases in relation to the family income when establishing the percentage for the amount of the subsidy for the program.

(b) The amount of the subsidy and parent copayment must be sufficient to allow the family to access child care providers pursuant to s. 1002.88 and enable the parent to achieve self-sufficiency.

(3) For a parent to receive a subsidy under the program, he or she must:

(a) Submit an application to the early learning coalition in a format prescribed by the Department of Education.

(b) Provide any documentation necessary to verify the parent's eligibility to receive the subsidy.

(c) Be responsible for the payment of all child care expenses in excess of the amount of the subsidy.

Section 12. For the 2024-2025 fiscal year, the sum of $23,076,259 in nonrecurring funds is appropriated from the General Revenue Fund to the Department of Education to implement the School Readiness Subsidy Program established in s. 1002.935,

Florida Statutes, as created by this act. The funds shall be placed in reserve. The Department of Education is authorized pursuant to chapter 216, Florida Statutes, to submit budget amendments requesting the release of the funds. The release of funds is contingent upon the submission of an allocation plan developed by the Department of Education in collaboration with the early learning coalitions established under s. 1002.83, Florida Statutes.

Section 13. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1269 Potency for Adult Personal Use of Marijuana
SPONSOR(S): Healthcare Regulation Subcommittee, Massullo and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	13 Y, 4 N, As CS	McElroy	McElroy
2) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

Delta-9-tetrahydrocannabinol (THC) is the psychoactive chemical in marijuana. The full extent of the health impact of consuming products with high concentration of THC is unknown; however, research indicates that such use significantly increases the risk of marijuana-associated psychosis. Studies have found daily use, especially of high-potency marijuana (over 10 percent THC), is strongly associated with earlier onset of psychosis and the development of schizophrenia in marijuana users. Some studies have also shown that marijuana with a THC concentration of 10 percent or less is effective for medical treatment, including the relief of neuropathic pain and pain caused by conditions such as HIV/AIDS, multiple sclerosis, and post-traumatic surgical pain.

Currently, 24 states and the District of Columbia have legalized the adult use of marijuana. Two states, Connecticut and Vermont, currently have potency limits for adult use marijuana products. Both states prohibit cannabis flower with a total THC concentration greater than 30% and solid or liquid concentrate cannabis products with a total THC concentration of greater than 60% from being cultivated, produced or sold in the adult use market.

Adult personal use of marijuana is not legal in Florida; however, there is a pending ballot initiative to legalize adult personal use. Although Florida does not have an adult personal use program it does have a well-established medical marijuana program, including 25 licensed Medical Marijuana Treatment Centers (MMTC). Currently licensed MMTCs would be eligible to acquire, cultivate, process, manufacture, sell, and distribute adult personal use marijuana products if the ballot initiative were to pass. The THC concentration of the products currently offered by MMTCs varies by the route of administration from .4 percent to 90 percent THC.

CS/HB 1269 establishes THC potency limits for various adult personal use marijuana products. Marijuana in the form for smoking cannot have a THC potency of greater than 30 percent and all other marijuana products, excluding edibles, cannot have a THC potency of greater than 60 percent. Identical to the potency limits in the medical marijuana program, the bill prohibits multi-serving edibles from containing more than 200 mg of THC and a single serving edible from containing more than 10 mg of THC.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Research on the Health Effects of THC

Although there are more than 100 cannabinoids in a marijuana plant, the two main cannabinoids are Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).[1] THC is a mind-altering chemical that increases appetite and reduces nausea and may also decrease pain, anxiety, and muscle control problems.[2] Though CBD may also have an effect on the mind, it does not produce the high or sense of euphoria associated with THC. CBD has been shown to help with anxiety, depression, reducing pain and inflammation, controlling epileptic seizures, and possibly treating psychosis or mental disorders.[3]

Marijuana has changed over time. The THC concentration in commonly cultivated marijuana plants increased three-fold between 1995 and 2014 (4% and 12% respectively).[4] Conversely, the CBD content decreased from .28% in 2001 to .15% in 2014. In 1995, the level of THC was 14 times higher than its CBD level. In 2014, the THC level was 80 times the CBD level.[5] The marijuana available today is much stronger than previous versions.

Some studies have shown that marijuana with a THC concentration of 10% or less is effective for medical treatment, including the relief of neuropathic pain and pain caused by conditions such as HIV/AIDS, multiple sclerosis, post-traumatic surgical pain.[6] Studies on the use of marijuana for pain relief found that marijuana cigarettes with a THC concentration between 2% and 10% THC provided sufficient pain relief,[7] with one study finding that medium-dose marijuana cigarettes with 3.5% THC were as effective as higher dosed marijuana cigarettes at 7% THC.[8]

A 2014 New England Journal of Medicine study warned that long-term marijuana use can lead to addiction and that adolescents are more vulnerable to adverse long-term outcomes from marijuana use.[9] Specifically, the study found that, as compared with persons who begin to use marijuana in adulthood, those who begin in adolescence are approximately 2 to 4 times as likely to have symptoms

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[1] U.S. Department of Health & Human Services, National Center for Complementary and Integrative Health, *Cannabis (Marijuana) and Cannabinoids: What You Need To Know*, available at https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids-what-you-need-to-know (last visited January 30, 2024).
[2] Healthline, *CBD vs. THC: What's the Difference?*, https://www.healthline.com/health/cbd-vs-thc (last visited January 30, 2024).
[3] *Id*.
[4] *U.S. Surgeon General's Advisory: Marijuana Use and the Developing Brain*, https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-marijuana-use-and-developing-brain/index.html (last visited January 30, 2024).
[5] ElSohly, M.A., Mehmedic, Z., Foster, S., Gon, C., Chandra, S. and Church, J.C. *Changes in Cannabis Potency Over the Last 2 Decades (1995-2014): Analysis of Current Data in the United States,* Biological Psychiatry. April 1, 2016; 79(7):613-619.
[6] Igor Grant,1 J. Hampton Atkinson, Ben Gouaux, and Barth Wilsey. *Medical Marijuana: Clearing Away the Smoke.* Open Neurol J. 2012; 6: 18–25. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3358713/; Ellis RJ, Toperoff W, Vaida F, et al. *Smoked Medicinal Cannabis for Neuropathic Pain in HIV: A Randomized, Crossover Clinical Trial,* Neuropsychopharmacology, 2009; 34(3):672-680, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3066045/ (last viewed on January 30, 2024); Abrams DI, Jay CA, Shade SB, et al. *Cannabis in Painful HIV-associated Sensory Neuropathy: A Randomized Placebo-controlled Trial.* Neurology. 2007; 68(7):515-521 available at https://pubmed.ncbi.nlm.nih.gov/17296917/ (last viewed on January 30, 2024); Wilsey B, Marcotte T, Tsodikov A, et al. *A Randomized, Placebo-controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain,* J Pain. 2008;9(6):506-521, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4968043/ (last viewed on January 30, 2024); Wallace M, Schulteis G, Atkinson JH, et al. *Dose-dependent Effects of Smoked Cannabis on Capsaicin-induced Pain and Hyperalgesia in Healthy Volunteers.* Anesthesiology. 2007; 107(5):785–96, available at https://pubs.asahq.org/anesthesiology/article/107/5/785/7080/Dose-dependent-Effects-of-Smoked-Cannabis-on (last viewed on January 30, 2024).
[7] *Id*.
[8] Wilsey B, Marcotte T, Tsodikov A, et al. *A Randomized, Placebo-controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain*. J Pain. 2008; 9(6):506–21, available at https://pubmed.ncbi.nlm.nih.gov/18403272/ (last viewed on January 30, 2024).
[9] Volkow, N.D., Baler, R.D., Compton, W.M. and Weiss, S.R., *Adverse Health Effects of Marijuana Use,* NEW ENG. J. MED., June 5, 2014, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827335/ (last viewed on January 30, 2024).

of marijuana dependence within 2 years after first use.[10] The study also found that marijuana-based treatments with THC may have irreversible effects on brain development in adolescents as the brain's endocannabinoid system undergoes development in childhood and adolescence.[11]

Heavy use of marijuana by adolescents is associated with impairments in attention, learning, memory, poor grades, high drop rates and I.Q. reduction.[12] Though the full extent of the health impact of consuming products with high concentration of THC is unknown, research indicates that use of such products significantly increases the risk of marijuana-associated psychosis,[13] regardless of age at first use or the type of marijuana used.[14] A 2019 European study showed that the use of high-potency marijuana (over 10% THC) only modestly increased the odds of a psychotic disorder compared to never using it; however, individuals who started using high-potency marijuana by age 15 showed a doubling of risk.[15] The European study also found that daily use of high-potency cannabis increased the risk of psychotic disorder nearly five times compared with never having used marijuana.[16]

Another study found that frequent use of marijuana or use of marijuana with high THC potency increased the risk of schizophrenia six-fold.[17] According to a literature review of studies on the impact of marijuana use on mental health published in the Journal of the American Medical Association Psychiatry, there is strong physiological and epidemiological evidence supporting a link between marijuana use and schizophrenia. High doses of THC can cause acute, transient, dose-dependent psychosis, which are schizophrenia-like symptoms. Additionally, prospective, longitudinal, and epidemiological studies have consistently found an association between marijuana use and schizophrenia in which marijuana use precedes psychosis, independent of alcohol consumption, and even after removing or controlling for those individuals who had used other drugs.[18]

Even though marijuana use may have been discontinued long before the onset of psychosis, studies have found that the age at which marijuana use begins appears to correlate with the age of onset of psychosis, which suggests that early marijuana use plays a role in initiating psychosis that is independent of actual use.[19] Overall, studies have found that the association between marijuana use and chronic psychosis (including a schizophrenia diagnosis) is stronger in those individuals who have had heavy or frequent marijuana use, use marijuana during adolescence, or use marijuana with high THC potency.[20]

While studies have not shown that marijuana use alone is either necessary or sufficient for the development of schizophrenia, studies suggests that marijuana use may initiate the emergence of a lasting psychotic illness in some individuals, especially those with a genetic vulnerability to develop a psychotic illness.[21]

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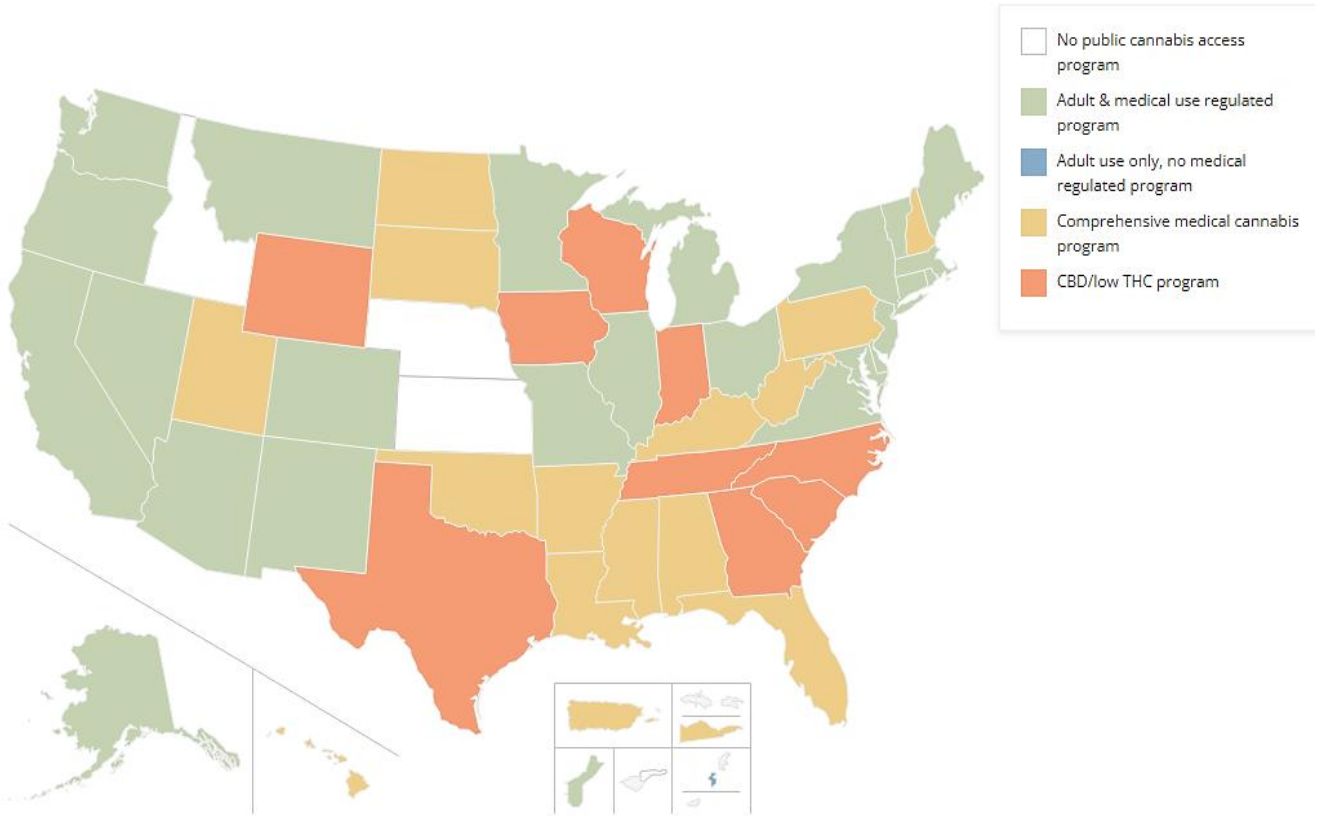
[10] *Id*.
[11] *Id*.
[12] *See* footnote 9; *see also The Influence of Marijuana Use on Neurocognitive Functioning in Adolescents*, Schweinsburg AD, Brown SA, Tapert SF, Curr Drug Abuse Rev. 2008;1(1):99-111, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2825218/ (last viewed on January 30, 2024).
[13] Robin Murray, Harriet Quigley, Diego Quattrone, Amir Englund and Marta Di Forti, *Traditional Marijuana, High-Potency Cannabis and Cannabinoids: Increasing Risk for Psychosis*, World Psychiatry, 2016 Oct; 15(3): 195–204, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5032490/ (last viewed January 30, 2024).
[14] Di Forti et al. *The Contribution of Cannabis Use to Variation in the Incidence of Psychotic Disorder Across Europe (EU-GEI): A Multicenter Case-control Study*. Lancet Psychiatry. 2019; 6:427-36, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7646282/ (last viewed on January 30, 2024); *High-Potency Cannabis and Incident Psychosis: Correcting the Causal Assumption*, The Lancet, Volume 6, Issue 6, June 2019, available at https://doi.org/10.1016/S2215-0366(19)30174-9 (last viewed January 30, 2024); *High-Potency Cannabis and Incident Psychosis: Correcting the Causal Assumption – Author's Reply*, The Lancet, Volume 6, Issue 6, June 2019 available at https://doi.org/10.1016/S2215-0366(19)30176-2 (last viewed January 30, 2024).
[15] *Id*. at 430.
[16] *Id*. at 431. The odds were lower for those who use low-potency marijuana daily.
[17] Nora D. Volkow, MD; James M. Swanson, PhD; A. Eden Evins, MD; Lynn E. DeLisi, MD; Madeline H. Meier, PhD; Raul Gonzalez, PhD; Michael A. P. Bloomfield, MRCPsych; H. Valerie Curran, PhD; Ruben Baler, PhD., *Effects of Cannabis Use on Human Behavior, Including Cognition, Motivation, and Psychosis: A Review.* JAMA Psychiatry. 2016; 73(3):292-297, available at https://core.ac.uk/reader/79505094?utm_source=linkout (last viewed January 30, 2024).
[18] *Id*.
[19] *Id*.
[20] *Id*.
[21] *Id*.

State Legalization of Adult Use of Marijuana

Currently, 24 states and the District of Columbia have legalized the adult use of marijuana, as indicated by the map below.[22]



State Potency Limits for Adult Use Marijuana

Two states, Connecticut and Vermont, currently have potency limits for adult use marijuana products. Both states prohibit cannabis flower with a total THC concentration greater than 30% and solid or liquid concentrate cannabis products with a total THC concentration of greater than 60% from being cultivated, produced or sold in the adult use market.[23] Both states provided an exception to these potency limits for pre-filled cartridges for vape pens.[24]

Florida - Adult Personal Use of Marijuana

Adult personal use of marijuana is not legal in Florida; however, there is a pending ballot initiative to legalize adult personal use. The proponents of the initiative were required to obtain 891,523 valid signatures to qualify the initiative for the ballot. The proponents have met this requirement as there are currently 1,033,770 valid signatures for the initiative.[25] The ballot summary of the initiative states:[26]

[22] *Map Monday: Nearly Every State Redefining Cannabis Access*, National Conference of State Legislatures available at https://www.ncsl.org/resources/map-monday-nearly-every-state-redefining-cannabis-access (last visited on February 7, 2024). States include: California, Alaska, Nevada, Oregon, Washington, Maine, Colorado, Montana, Vermont, Rhode Island, New Mexico, Michigan, Arizona, New Jersey, Delaware, Connecticut, Massachusetts, Illinois, Maryland, Minnesota, New York, Ohio, Missouri, Virginia.
[23] See CT ST s. 21a-421j and VT ST T.7 s. 868.
[24] *Id.*
[25] Adult Personal Use of Marijuana 22-05, Florida Division of Elections, available at https://dos.elections.myflorida.com/initiatives/initdetail.asp?account=83475&seqnum=2 (last viewed January 31, 2024).
[26] Constitutional Amendment Full Text, available at https://initiativepetitions.elections.myflorida.com/InitiativeForms/Fulltext/Fulltext_2205_EN.pdf (last viewed January 31, 2024).

Allows adults 21 years or older to possess, purchase, or use marijuana products and marijuana accessories for non-medical personal consumption by smoking, ingestion, or otherwise; allows Medical Marijuana Treatment Centers, and other state licensed entities, to acquire, cultivate, process, manufacture, sell, and distribute such products and accessories. Applies to Florida law; does not change, or immunize violations of, federal law. Establishes possession limits for personal use. Allows consistent legislation. Defines terms. Provides effective date.

The State of Florida requested an advisory opinion from the Florida Supreme Court as to the validity of the initiative specifically seeking guidance on whether the initiative and the ballot title and summary comply with applicable Florida law.[27] Oral arguments occurred in November 2023, and the issue remains pending before the court.[28]

Florida Potency of Medical Marijuana Products

Although Florida does not have an adult personal use program it does have a well-established medical marijuana program. Section 381.986, F.S., authorizes patients with any of the following debilitating medical conditions to obtain medical marijuana from Medical Marijuana Treatment Centers (MMTC):

- Cancer
- Epilepsy
- Glaucoma
- Positive status for human immunodeficiency virus
- Acquired immune deficiency syndrome
- Post-traumatic stress disorder
- Amyotrophic lateral sclerosis
- Crohn's disease
- Parkinson's disease
- Multiple sclerosis
- Medical conditions of the same kind or class as or comparable to those enumerated above

To obtain marijuana for medical use from a Medical Marijuana Treatment Center (MMTC), and maintain the immunity from criminal prosecution, the patient must obtain a physician certification from a qualified physician[29] and an identification card from the Department of Health.

As of January 26, 2024, there are 871,459 qualified patients, 2,781 qualified patients and 25 MMTCs with 618 dispensing locations.[30]

Currently licensed MMTCs would be eligible to acquire, cultivate, process, manufacture, sell, and distribute adult personal use marijuana products if the ballot initiative were to pass. The THC concentration of the products offered by MMTCs varies based on the route of administration, as evidenced by the table below.[31]

[27] *Advisory Opinion to the Attorney General Re: Adult Personal Use of Marijuana*, SC2023-0682, 2023, available at https://acis.flcourts.gov/portal/court/68f021c4-6a44-4735-9a76-5360b2e8af13/case/85dca015-d108-4595-8cdb-d4488890aa88 (last viewed January 31, 2024).
[28] *Id.*
[29] To certify patients for medical use of marijuana, a physician must hold an active, unrestricted license as an allopathic physician under chapter 458 or as an osteopathic physician under chapter 459 and comply with certain physician education requirements. See ss. 381.986(1)(m), F.S. and 381.986(3)(a), F.S.
[30] *Office of Medical Marijuana Use Weekly Updates, January 26, 2024,* DOH, Office of Medical Marijuana Use, available at https://knowthefactsmmj.com/wp-content/uploads/ommu_updates/2024/012624-OMMU-Update.pdf (last visited on January 29, 2024).
[31] *Florida's Medical Marijuana Program Update,* Office of Medical Marijuana Use, presented to the Health Care Regulation Subcommittee on December 13, 2023.

Route of Administration	Range in Potency Tetrahydrocannabinol (THC) Content as a Percentage of Volume	
	Lower Threshold	Upper Threshold
Inhalation	60.0%	90.0%
Oral	0.5%	4.0%
Smoking	10.0%	28.0%
Sublingual	0.5%	90.0%
Suppository	1.3%	3.0%
Topical	0.4%	90.0%
Edibles	A multi-serving edible may not contain more than 200 mg of THC, and a single-serving edible, or a single serving portion of a multi-serving edible, may not exceed 10 mg of THC.	

Edibles are the only medical marijuana products currently subject to THC potency limits.

Effect of the Bill

CS/HB 1269 establishes THC potency limits for various adult personal use marijuana products. Marijuana in the form for smoking cannot have a THC potency of greater than 30 percent and all other marijuana products, excluding edibles, cannot have a THC potency of greater than 60 percent. Identical to the potency limits in the medical marijuana program, the bill prohibits multi-serving edibles from containing more than 200 mg of THC and a single serving edible from containing more than 10 mg of THC.

The bill provides an effective date of 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.9861, F.S., relating to the potency limits for adult personal use of marijuana.
Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

A. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

B. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

C. 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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 1, 2024, the Healthcare Regulation Subcommittee adopted an amendment and reported the bill favorable. The amendment established a THC potency limit for marijuana in the form for smoking in the adult personal use marijuana program. Such marijuana may not have a THC potency of greater than 30 percent.

This analysis is drafted to the committee substitute as passed by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to potency for adult personal use of marijuana; creating s. 381.9861, F.S.; providing definitions; specifying the authorized potency of tetrahydrocannabinol when consuming marijuana for personal use; providing a contingent effective date.

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

Section 1. Section 381.9861, Florida Statutes, is created to read:

381.9861 Potency limits for adult personal use of marijuana.—

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

(a) "Edibles" means commercially produced food items made with marijuana oil, but no other form of marijuana.

(b) "Marijuana" means all parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin, including low-THC cannabis.

(c) "Marijuana delivery device" means an object used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing marijuana into the human body.

(d) "Personal use" means possession, purchase, or use of marijuana or a marijuana delivery device by an adult 21 years of age or older for nonmedical consumption.

(e) "Potency" means the relative strength of cannabinoids, and the total amount, in milligrams, of tetrahydrocannabinol as the sum of delta-9-tetrahydrocannabinol, plus 0.877 multiplied by tetrahydrocannabinolic acid, plus delta-8-tetrahydrocannabinol and cannabidiol as the sum of cannabidiol, plus 0.877 multiplied by cannabidiolic acid in the final product.

(2) Marijuana for personal use may not have a tetrahydrocannabinol potency, by weight or volume, of greater than 30 percent for marijuana in a form for smoking or greater than 60 percent in the final product for all other forms of marijuana, excluding edibles. Edibles for personal use may not contain more than 200 milligrams of tetrahydrocannabinol and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol.

Section 2. This act shall take effect 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

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 & Human Services Committee

Representative Massullo offered the following:

Amendment

Remove lines 40-43 and insert:

marijuana, excluding edibles and marijuana products prepackaged for use in a vapor-generating electronic device, as defined in s. 386.203.

(a) Edibles for personal use may not contain more than 200 milligrams of tetrahydrocannabinol and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent.

(b) A container for marijuana products prepackaged for use in a vapor-generating electronic device, as defined in s. 386.203, may not exceed more than 1,000 milligrams total volume.

Section 2. Section 1 of chapter 2017-232, Laws of Florida, is amended to read: Section 1. Legislative intent.—It is the intent of the Legislature to implement s. 29, Article X of the State Constitution by creating a unified regulatory structure. ~~If s. 29, Article X of the State Constitution is amended or a constitutional amendment related to cannabis or marijuana is adopted, this act shall expire 6 months after the effective date of such amendment.~~

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1501 Health Care Innovation
SPONSOR(S): Health Care Appropriations Subcommittee, Gonzalez Pittman
TIED BILLS: **IDEN./SIM. BILLS:** SB 7018

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	17 Y, 0 N	DesRochers	McElroy
2) Health Care Appropriations Subcommittee	14 Y, 0 N, As CS	Aderibigbe	Clark
3) Health & Human Services Committee		DesRochers	Calamas

SUMMARY ANALYSIS

HB 1501 creates the Health Care Innovation Council, a 15-member council within the Department of Health (DOH) to facilitate public meetings across the state to lead discussions with innovators, developers, and implementers of technologies, workforce pathways, service delivery models, or other solutions. The bill requires the council to create best practice recommendations and focus areas for the advancement of the delivery of health care in Florida, with an emphasis on:

- Increasing efficiency in the delivery of health care;
- Reducing strain on the health care workforce;
- Increasing public access to health care;
- Improving patient outcomes;
- Reducing unnecessary emergency department visits; and
- Reducing costs for patients and the state without reducing the quality of patient care.

The bill creates a revolving loan program within the DOH to provide low-interest loans to applicants to implement one or more innovative technologies, workforce pathways, or service delivery models in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination thereof to improve the quality and delivery of health care in measurable and sustainable ways that will lower costs and allow that value to be passed onto health care consumer.

The council will review loan applications and submit to the DOH a prioritized list of proposals recommended for funding. Loan recipients enter into agreements with the DOH for loans of up to 10-year terms for up to 50 percent of the proposal costs, or up to 80 percent of the costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients.

The bill requires both the council and the DOH to publicly report certain information related to the activities required under the bill and requires the Office of Economic and Demographic Research (EDR) and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to evaluate specified aspects of the revolving loan program every five years.

The bill provides an appropriation of $51,250,000 in recurring and nonrecurring funds to DOH to implement its provisions, and has no fiscal impact on local government.

The bill takes effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Challenges of the Health Care System

There are numerous challenges facing the health care system in the United States, including provider shortages, lack of access for certain populations, affordability, and ongoing challenges with health care outcomes for certain populations. Compared with other wealthy nations, Americans have poorer health, lower life expectancy, and less access to health care.[1]

Health Care Professional Shortages

The United States has a current health care professional shortage. The U. S. Department of Health and Human Services designates an area, population group, or facility as a Health Professional Shortage Area (HPSA) if it is experiencing a shortage of professionals.[2] The three types of HPSAs are:

- Geographic HPSAs, which have a shortage of services for the entire population within an established geographic area;
- Populations HPSAs, which have a shortage of services for a particular population subset within an established geographic area, such as low income, migrant farmworker, or Medicaid eligible; and
- Facility HPSAs, which indicate shortages in facilities such as correctional facilities, state or county hospitals with a shortage of psychiatrists, and other public or non-private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers.

As of December 3, 2023, there are 8,544 Primary Care HPSAs, 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.[3]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] By 2030, all baby-boomers will be over the age of 65, and by 2034, it is projected that the number of individuals over the age of 65 will surpass the number of children under the age of 18 for the first time in U.S. history.[6] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Health care workers may experience an extreme amount of stress due to the demanding work conditions, including taxing work, exposure to infectious diseases, long hours, and challenging

[1] Centers for Disease Control and Prevention, *U.S. Health Disadvantage: Causes and Potential Solutions*, available at https://www.cdc.gov/policy/chep/health/index.html (last visited January 9, 2023).
[2] U.S. Department of Health and Human Services, Guidance Portal, *Health Professional Shortage Areas (HPSAs and Medically Underserved Populations (MUA/P) Shortage Designation Types* (Aug. 1, 2019), available at https://www.hhs.gov/guidance/document/hpsa-and-muap-shortage-designation-types (last visited January 9, 2023).
[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited December 19, 2023).
[4] The U.S. population is projected to increase from almost 336 million in 2023 to nearly 370 million in 2080, before decreasing to 366 million in 2100. *See* U.S. Census Bureau, *U.S. and World Population Clock*, available at https://www.census.gov/popclock/, and U.S. Census Bureau, U.S. Population Projected to Begin Declining in Second Half of Century (Dec. 19, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited January 9, 2023).
[5] *Id*. at 33.
[6] J. Vespa, L. Medina, and D. Armstrong, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060*, United States Census Bureau (Mar. 208, rev. Feb, 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited January 9, 2023).

interactions with coworkers, patients, and their families.[7] Prior to the COVID-19 pandemic, the National Academy of Medicine found that burnout had reached a crisis level, with 35-45 percent of nurses and physicians and 45-60 percent of medical students and residents reporting symptoms of burnout.[8] During the pandemic, the high levels of stress and the increased demands for care led to record numbers of health care workers quitting or planning to quit.[9] In 2022, nearly one half of health care workers reported burnout.[10]

Florida is not immune to the national problem and is also experiencing a health care practitioner shortage. This is evidenced by the fact that as of September 30, 2023, there are 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.[11]

According to data from the DOH, by 2035, Florida will need 17,924 physicians, 50,700 registered nurses, and 4,000 licensed practical nurses to meet the demand in Florida.[12] In the next five years almost 10 percent of Florida physicians are planning to retire, and in nine counties, at least 25 percent of physicians are planning to retire.[13] Nurses make up the largest segment of Florida's health care workforce. Approximately 20 percent of the nursing workforce is over the age of 60 and may leave the workforce in the next five to ten years.[14]

Access to Health Care

Access to health care means the timely use of personal health services to achieve the best possible health outcomes.[15] There are several barriers that limit an individual's access to health care services. Some lack access because they reside in a medically underserved area or are members of a medically underserved population, which means that they lack access to primary health care services.[16] Florida has approximately 130 federally designated medically underserved areas or populations.[17]

Other factors that play a role in access to health care include health care affordability and the lack of health insurance coverage.[18] Studies show that having health insurance is associated with improved access to health services and better health monitoring. Additionally, nonfinancial barriers significantly impact a patient's ability to access care. Among the most prevalent nonfinancial barriers are the ability to get an appointment and inconvenient or unreliable transportation.[19]

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[7] J. Nigam, et. al., *Vital Signs: Health Worker-Perceived Working Conditions and Symptoms of Poor Mental Health – Quality of Worklife Survey, United States, 2018-2022*, MORBIDITY AND MORTALITY WEEKLY REPORT (Oct. 24, 2023), available at https://www.cdc.gov/mmwr/volumes/72/wr/pdfs/mm7244e1-H.pdf (last visited January 9, 2023).
[8] Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce* (2022),, available at https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf (last visited January 9, 2023). "Burnout" is an occupational syndrome characterized by a high degree of emotional exhaustion and depersonalization and a low sense of personal accomplishment at work.
[9] *Id*. at 14.
[10] *Supra*, FN 7.
[11] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 9, 2023).To generate the report, select "Designated HPSA Quarterly Summary."
[12] Presentation before the Florida Senate Committee on Health Policy by Emma Spencer, Department of Health, *Florida's Physician and Nursing Workforce* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 9, 2023).
[13] *Id*. Those counties are Glades, Gulf, Hamilton, Madison, Union, Calhoun, Hendry, Levy, and Liberty.
[14] *Id*.
[15] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2030, Access to Health Services*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services (last visited January 9, 2023). (Hereinafter "Healthy People 2030").
[16] Health and Resources Services Administration, *What is Shortage Designation?*, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation (last visited January 9, 2023).
[17] *See*, Heath Resources and Services Administration, *MUA Find*, available at https://data.hrsa.gov/tools/shortage-area/mua-find (last visited January 9, 2023).To generate a list of medically underserved areas and populations, select Florida as the search criteria.
[18] Centers for Disease Control and Prevention, Division of Heart Disease and Stroke Prevention, *Health Care Access*, available at https://www.cdc.gov/dhdsp/health_equity/health-care-access.htm (last visited January 9, 2023).
[19] Healthy People 2030, *supra*, note 156.

Health Care Outcomes

Although the United States spends more on health care per capita than other wealthy nations, it has some of the worst health care outcomes, according to an issue brief published by The Commonwealth Fund. Compared to other wealthy nations, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates, according to the issue brief.[20]

Sixty percent of adults in the U.S. have a chronic health condition, and 40 percent have two or more.[21] A chronic condition is a physical or mental health condition that lasts more than one year and causes functional restrictions or requires ongoing monitoring or treatment.[22] Chronic health conditions are the leading drivers of the nation's $4.1 trillion in health care costs, accounting for nearly 75 percent of aggregate health spending.[23] More than two thirds of all deaths are caused by one or more of the five most prevalent chronic health conditions: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Unfortunately, these outcomes are because of the nation's inability to effectively manage chronic conditions, which could be achieved by reducing unhealthy behaviors.[24]

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[25] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019. The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births. Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[26] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[27]

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[28] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida.

Infant mortality is the death of an infant before his or her first birthday. The leading causes of infant death are:

- Birth defects;
- Preterm birth and low birth weight;
- Sudden infant death syndrome;

[20] M. Gunja, Evan Gumas, and R. Williams, The Commonwealth Fund, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Jan. 31, 2023), available at https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 (last visited January 9, 2023).Other wealthy nations included in the study are Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom.
[21] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, About Chronic Diseases, available at https://www.cdc.gov/chronicdisease/about/index.htm (last visited January 9, 2023).
[22] W. Raghupathi and V. Rahupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, INTERNATIONAL JOURNAL ON ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH, 15(3):431 (Mar. 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/ (last visited January 9, 2023).
[23] *Id*., and CDC, *supra*, note 22.
[24] *Id*.
[25] U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health* (Dec. 2020), available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited January 9, 2023).
[26] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021* (March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited January 9, 2023).
[27] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic* (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (last visited January 9, 2023).
[28] Presentation before the Florida Senate Committee on Health Policy by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Secretary for Health, Department of Health, *Telehealth Minority Care Pilot Program* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 9, 2023).

- Injuries (i.e. suffocation); and
- Maternal pregnancy complications.[29]

The 2022 infant mortality rate in the U.S. was projected to be 5.6 deaths per 1,000 live births, which was three percent higher than the infant mortality rate in 2021 (5.44).[30] Except for the infants of Asian mothers, mortality rates have increased for all races: American Indian and Alaska native infants from 7.46 to 9.06; white infants from 4.36 to 4.52, black infants from 10.55 to 10.86, native Hawaiian and other Pacific Islander infants from 7.76 to 8.50, and Hispanic infants from 4.79 to 4.88 per 1,000 live births.[31] From 2021 to 2022, Florida's infant mortality rate increased from 5.90 to 5.98 per 1,000 live births. In 2020, the infant mortality rate was more than double the rate for white and Hispanic infants in Florida.[32]

Advancements in Health Care

In the last century, there have been tremendous advances in health care. From the development of vaccines to suppress the spread of diseases that were once considered debilitating or fatal, such as polio,[33] to the first successful organ transplant in 1954, and the development of numerous technologies and medical devices that provide new options for care and treatment.[34] During the last century, there have been numerous clinical innovations, such as the development of medications to make once fatal diseases an almost curable disease, such as AIDS, and the use of genetics to allow for individualized cancer treatments.[35] Despite the many advances in health care technology, the health care delivery system has been slower to change.

Historically, health care primarily involved the prevention and treatment of disease and episodes of acute care; however, health care has evolved to be increasingly occupied with the management of chronic health conditions. Chronic illness is the leading cause of illness, disability, and death in the United States, and accounts for 78 percent of health care expenditures.[36]

Within recent years, and especially during the COVID-19 pandemic, there has been an increase in interest in alternative delivery systems. For example, prior to the pandemic, the use of telehealth was growing; however, during the pandemic, the use of the technology rose by more than 760 percent.[37] As a subset of telehealth, many health care practitioners also adopted the use of remote patient monitoring to manage acute and chronic conditions. Remote patient monitoring may be used to assess high blood pressure, diabetes, weight loss or gain, heart conditions, chronic obstructive pulmonary disease, sleep apnea, or asthma. Using remote patient monitoring may reduce hospitalizations, reduce the length of hospital stays, reduce emergency department visits, and provide better health outcomes, among other things.[38]

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[29] Centers for Disease Control and Prevention, *Infant Mortality*, available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited December 19, 2023).
[30] D. Ely and K. Driscoll, Centers for Disease Control and Prevention, National Center for Health Statistics, *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File*, Vital Statistics Rapid Release, Report No. 33 (Nov. 2023), available at https://www.cdc.gov/nchs/data/vsrr/vsrr033.pdf (last visited January 9, 2023).
[31] *Id*.
[32] Department of Health, Infant Mortality in Florida, available at https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/infant-mortality-FL-.pdf (last visited January 9, 2023).
[33] The vaccine for polio was developed in the early 1950s. *See* World Health Organization, *History of the Polio Vaccine*, available at https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination (last visited January 9, 2023).
[34] Institute of Medicine, *Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK52825/ (last visited January 9, 2023).
[35] Gary Ahlquist, et. al, Strategy&, *The (R)evolution of Healthcare*, available at https://www.strategyand.pwc.com/gx/en/industries/health/the-revolution-of-healthcare.pdf (last visited January 9, 2023).
[36] Institute of Medicine, *supra*, note 37.
[37] Julia Shaver, M.D., *The State of Telehealth Before and After the COVID-19 Pandemic*, PRIMARY CARE 49(4): 517-530 (Dec. 2022), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/ (last visited January 9, 2023).
[38] Telehealth.HHS.gov, *Telehealth and Remote Patient Monitoring*, available at https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/telehealth-and-remote-patient-monitoring (last visited January 9, 2023).

Another technological advance that has been widely adopted is the use of an electronic health record (EHR).[39] EHRs offer a number of benefits, such as automating certain tasks, reducing the incidence of medical errors, and making health information more readily available, which reduces duplication of tests, delays in treatment, and enables patients to make better informed decisions.[40]

In addition to advancements in health care technologies and delivery systems, there has also been an evolution in payment models. In recent years, there has been a move to value-based care models. Under these models, providers, such as hospitals and physicians, are paid based on patient outcomes. Providers are rewarded for achievements such as helping the health of their patients to improve and reducing the effects of chronic illness.[41]

Health Care Innovation Initiatives

In recent years, both the state and federal governments have launched or funded programs to examine innovations in health care. Many of the programs were predicated on grants from the Center for Medicare and Medicaid Innovation (CMS Innovation Center).[42]

In 2010, Congress established the CMS Innovation Center to identify ways to improve health care quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[43] The CMS Innovation Center's demonstration projects and models measure the effect of potential program changes, while evaluation projects validate research and help to monitor the effectiveness of Medicare, Medicaid, and CHIP.[44]

The Office of Economic and Demographic Research

The Office of Economic and Demographic Research (EDR) is a research arm of the Legislature principally concerned with forecasting economic and social trends that affect policy making, revenues, and appropriations. EDR provides objective information to committee staffs and members of the Legislature in support of the policy making process. EDR publishes all of the official economic, demographic, revenue, and agency workload forecasts that are developed by Consensus Estimating Conferences and makes them available to the Legislature, state agencies, universities, research organizations, and the general public. EDR, through a contract with the University of Florida, arranges for annual estimates of population of each city and county in Florida, which provide the basis for revenue sharing programs.

The Office of Program Policy Analysis and Government Accountability

The Office of Program Policy Analysis and Government Accountability (OPPAGA) is a research arm of the Florida Legislature. OPPAGA was created by the Legislature in 1994 to help improve the performance and accountability of state government. OPPAGA provides data, evaluative research, and objective analyses to assist legislative budget and policy deliberations. OPPAGA conducts research as directed by state law, the presiding officers of the Legislature, or the Joint Legislative Auditing Committee.

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[39] An electronic health record is a digital version of a patient's paper chart. *See* The Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Frequently Asked Questions*, available at https://www.healthit.gov/faq/what-electronic-health-record-ehr (last visited January 9, 2023).
[40] Centers for Medicare and Medicaid Services, *Electronic Health Records*, available at https://www.cms.gov/priorities/key-initiatives/e-health/records (last visited January 9, 2023).
[41] NEJM Catalyst, *What is Value-Based Healthcare?* (Jan. 1, 2017), available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558 (last visited January 9, 2023).
[42] For example, see the Delaware Center for Health Innovation, available at https://www.dehealthinnovation.org/; Rhode Island Health Care Innovation Initiative, available at https://eohhs.ri.gov/initiatives/healthcare-innovation; Oklahoma Center for Health Innovation and Effectiveness, available at https://oklahoma.gov/health/about-us/center-for-health-innovation-and-effectiveness.html (all sites last visited January 9, 2023).
[43] Centers for Medicare and Medicaid Services, *About the CMS Innovation Center*, available at https://www.cms.gov/priorities/innovation/About (last visited January 9, 2023).
[44] Centers for Medicare and Medicaid Services, *CMS Innovation Center Programs*, available at https://data.cms.gov/cms-innovation-center-programs (last visited January 9, 2023).

Effect of Proposed Changes

This bill creates s. 381.4015, F.S.,[45] to set forth legislative intent related to health care innovation in this state and create a framework to implement such intent. The intent is to harness the innovation and creativity of entrepreneurs and businesses, in collaboration with the state's health care system and stakeholders, to lead discussion on innovations that will address challenges in the health care system and transform the delivery and strengthen the quality of health care in Florida.

Health Care Innovation Council

The bill creates the Health Care Innovation Council, a 15-member council within the DOH. The Lieutenant Governor serves as the chair of the council and as an ex officio, nonvoting member. The Secretary of Health Care Administration, the Secretary of Children and Families, the director of the Agency for Persons with Disabilities, the State Surgeon General, and the Secretary of Elderly Affairs all serve as ex officio, nonvoting members. The chair of the Council of Florida Medical School Deans serves as a voting member.

The President of the Senate and the Speaker of the House of Representatives each make one appointment to the council. Legislative appointments must be a person from the health care sector who has senior level experience in reducing inefficiencies in health care delivery systems; from the private sector who has senior level experience in cybersecurity or software engineering in the health care sector; who has expertise in emerging technology that can be used in the delivery of health care; or who has experience in finance or investment or in management and operation of early stage companies.

The remainder of the council consists of the following appointments by the Governor:

- A licensed physician;
- An employee of a licensed hospital;
- A licensed nurse;
- A Florida resident to represent the interest of health care patients;
- An employee of a health insurer or health maintenance organization; and
- A representative of the long-term care facility industry.

Appointments must be made by July 1, 2024. Appointees serve two-year terms and may be reappointed for no more than four consecutive terms.[46] Vacancies are filled in the same manner as the appointment, and members whose terms are expired may continue to serve for up to six months until replaced or reappointed. Members serve without compensation but are entitled to per diem and travel expenses. A member may be removed for cause by the appointing entity. Members who are not already required to file a financial disclosure statement must file a disclosure of financial interests.

The bill requires the council to hold its first meeting by September 1, 2024. The council is required to meet at least quarterly at the call of the chair, and in order to provide an opportunity for the broadest public input, must hold a majority of its meetings during the year geographically dispersed across the state. Meetings are encouraged to provide opportunities for demonstrations or presentations of innovative solutions in person. The council is subject to the public records requirements under ch. 119, F.S., and the public meetings requirements of ch. 286, F.S.

A majority of the members represents a quorum, which is required for meetings and can be established by conducting the meeting using teleconference or other electronic means. An affirmative vote by a majority of members present at the meeting is necessary for any official action.

[45] The section expires on July 1, 2043.
[46] The bill provides that the legislative appointees, the physician, and the nurse all serve initial terms of three years in order to create staggered terms.

Council members may not vote or consider any matters which would directly benefit the member or which would benefit a relative or person or entity with which the member has a business relationship.[47]

State agencies and statutorily created state entities are required to assist and cooperate with the council as requested. The DOH is required to administratively support the council, including providing reasonable support staff and maintaining a website for the council.

Council Duties

The bill charges the council with several duties, including adoption of best practices and focus areas. The council is required to adopt a document that sets forth a mission statement, goals, and objectives for the council to function and meet the purposes of the law. This must be adopted by February 1, 2025, and updated as necessary.

The council must facilitate public meetings at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions. The work:

- Must cover concepts that address challenges to the health care system as they develop in real time and concepts that advance the delivery of health care in this state through technology and innovation.
- Must give consideration to how the concepts:
    - Increase efficiency in the health care system in this state;
    - Reduce strain on the state's health care workforce;
    - Improve patient outcomes;
    - Expand public access to health care services in this state; or
    - Reduce costs for patients and the state without reducing the quality of patient care.
- May consider broad community or statewide issues or needs to be addressed.
- May include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payers, patients, and the state.
- May include coordination with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business incubators, development organizations, or institutions of higher education to include emerging and early stage concepts in the discussions.
- May bring information technology technical experts to lead discussions on recommended structures and integrations of information technology products, services, and solutions.

The bill requires the council to annually distinguish the most impactful concepts, projects, and initiatives. The recognition must be for those that the council finds to have a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in Florida. The council may develop a logo for awardees to display.

The bill requires the council to use input received to develop and update best practice recommendations. The best practice recommendations must:

- Be made for health care service delivery models and focus on how to explore implementation of innovations and how to implement new technologies and strategies, at a minimum;
- Be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency department visits, and reducing costs for patients and the state without reducing the quality of patient care; and

[47] "Relative" is defined as a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law. "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association.

- Specifically for information technology, also recommend actions to guide the selection of technologies and innovations, which may include considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training.
- Be updated as necessary.

The council must develop and update a list of focus areas for the advancement of the delivery of health care. The council can adopt broad or specific focus areas, and the bill sets forth topics that must be considered at a minimum, including:

- The health care workforce (such as approaches to cultivate interest in the workforce, efforts to improve the workforce, education pathways, and use of technology to reduce workforce burdens).
- The provision of patient care in the most appropriate setting and reduction of unnecessary emergency department visits (such as use of advanced technologies to improve patient outcomes, use of early detection devices, at-home patient monitoring, advanced at-home care, and advanced adaptive equipment).
- The delivery of primary care through methods, practices, or procedures that increase efficiencies.
- The technical aspects of the provision of health care (such as interoperability of electronic health records systems and the protection of health care data and systems).

The council's duties also include identifying and recommending changes to law or administrative changes that are necessary to advance, transform, or innovate health care or to implement the council's duties or recommendations. The DOH is required to incorporate council recommendations into its duties, including updating administrative rules or procedures, as appropriate.

The council must submit an annual report each December 1 on the council's activities, including:

- An update on the status of the delivery of health care in Florida;
- Information on implementation of best practices by Florida health care industry stakeholders; and
- Highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by Florida health care industry stakeholders.

Technical Assistance for Funding Opportunities

The DOH must identify and publish on its website a list of federal, state, and private sources of funding opportunities available to implement innovative technologies and service delivery models in health care. The information must include details and eligibility requirements for each opportunity. The DOH must provide technical assistance to apply for such funding upon request and is encouraged to foster working relationships that will allow the department to refer interested applicants to appropriate contacts for the funding opportunities.

Revolving Loan Program

The bill creates a revolving loan program within the DOH to provide funding for applicants seeking to implement innovative solutions. Certain entities licensed, registered, or certified by the Agency for Health Care Administration and educational or clinical training providers in partnership with one of the entities, may apply for a loan.[48]

The bill requires the DOH to establish eligibility criteria that:

[48] Those entities licensed, registered, or certified pursuant to s. 408.802, except for subsections (1), (3), (13), (23), and (25) of that sections, are eligible to apply.

- Incorporate recommendations of the council based on input received, focus areas developed, and best practices recommended.
- Determine which proposals are likely to provide the greatest return to the state, taking into consideration the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

The bill provides that an applicant that has a conflict of interest relationship with a council member may not receive a loan unless the council member recused herself or himself from consideration of the application. If a council member voted to recommend an application for funding with which the member has a conflict of interest, the applicant may not be awarded a loan. A council member may not receive a loan under the program.

The DOH is required under the bill to set application periods to apply for loans and may set up to four application periods in a fiscal year. The DOH must work with the council if application periods include separate priority for current focus areas adopted by the council. The availability of loans will be publicized to stakeholders, education or training providers, and others. The DOH will receive the applications and determine whether the applications are complete and whether the applicant has demonstrated ability to repay the loan. Within 30 days of the close of the application period, the DOH will forward the complete applications to the council.

The council must review submitted applications using the criteria and processes and format adopted by the DOH by rule. The bill requires priority for applicants that are located in a rural or medically underserved area and are either rural hospitals or nonprofit entities that accept Medicaid patients. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination of the above, which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

Approved lists of recommended applications for funding, arranged in order of priority and as required by the application period, are to be submitted by the council to the DOH. The DOH is directed under the bill to award the loans based on demonstrated need and availability of funds.

Loans may be made for up to 50 percent of the total projected implementation costs, or up to 80 percent of the total projected implementation costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients. However, the DOH may not award more than 10 percent of the total allocated funds for the fiscal year to a single applicant. An applicant may only receive one loan per fiscal year, and if the applicant has an outstanding loan, it may apply for a new loan only if the outstanding loan is in good standing.

The loan term is up to 10 years and may have an interest rate of up to 1 percent. Loan recipients must enter into written agreements with the DOH to receive the loan. At a minimum, the agreement must specify:

- The total amount of the award.
- The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.
- The information to be reported on actual implementation costs, including the share from non-state resources.
- The schedule for payment.

- The data and progress reporting requirements and schedule.[49]
- Any sanctions that would apply for failure to meet performance conditions.

Loan recipients can request the DOH to provide technical assistance, if needed.

The DOH is required to maintain the loan funds in a separate account in its Grants and Donations Trust Fund. All loan repayments of principal must be returned to the revolving loan fund and made available to make loans. Loans appropriated to the program are not subject to reversion.

The DOH is authorized to contract with a third-party administrator to administer the revolving loan program, including loan servicing, and manage the revolving loan fund. A contract for a third-party administrator must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

The bill authorizes the DOH to adopt rules for the revolving loan program, including establishing the loan application process, eligibility criteria, and application requirements. The bill specifies that conditions are deemed met in order for the DOH to adopt emergency rules to implement this bill. The emergency rules are effective for six months after adoption and may be renewed until permanent rules are adopted pursuant to ch. 120, F.S.

Reporting

The bill requires the DOH to publish information on its website related to loan recipients, including the written agreements, the performance conditions and status, and the total amount of funds disbursed to date. Information related to a loan must be updated annually on the award date of the loan.

Each September 1, beginning in 2025, the DOH must post on its website a report on health care innovation which includes all of the following information:

- A summary of the adoption and implementation of recommendations of the council during the previous fiscal year.
- An evaluation of actions and related activities to meet the purposes set forth in the bill.
- Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in the bill.
- The number of applications for loans, the types of proposals received, and an analysis on the relationship between the proposals and the purposes of the bill.
- The amount of funds allocated and awarded for each loan application period, as well as any funds not awarded in that period.
- The amount of funds paid out during the fiscal year and any funds repaid or unused.
- The number of persons assisted and outcomes of any technical assistance requested for loans and any federal, state, or private funding opportunities.

Evaluation

The bill directs EDR and OPPAGA to each evaluate specified aspects of the revolving loan program every five years, as follows.

The first report by EDR is due October 1, 2029, and must be a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program. The evaluation must include, but is not limited to, separate calculations of the state's return and the economic value to residents of this state and the identification of any cost savings to patients or the state and the impact on the state's health care workforce.

The first report by OPPAGA is due October 1, 2030, and must be an evaluation of the administration and efficiency of the revolving loan program. The evaluation must include, but is not limited to, the

[49] The DOH is required to develop uniform data reporting requirements in order to evaluate the performance of the implemented proposals. The data collected must be shared with the council.

degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in the EDR evaluation without reducing the quality of patient care.

Each report must include recommendations for consideration by the Legislature.

The bill grants EDR and OPPAGA access to all data necessary to complete their evaluations, including any confidential data, and authorizes EDR and OPPAGA to collaborate on data collection and analysis.

The reports must be sent to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Creating s. 381.4015, F.S., relating to Florida health care innovation.
Section 2: Creating an unnumbered section of law.
Section 3: Providing appropriations.
Section 4: Providing an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Upon implementation, the DOH will incur costs to administratively support the council, including travel and per diem expenses of members and website hosting, and to implement and administer the revolving loan program. OPPAGA will incur costs in 2030 and EDR will incur costs in 2029, and every five years thereafter, respectively, to conduct their evaluations of the program.

   The bill appropriates the following to implement its provisions:

   - $250,000 in nonrecurring funds to DOH to implement and administer the Health Care Innovation Council;
   - $1 million in recurring funds to DOH to administer the Council beginning in Fiscal Year 2024-2025; and
   - $50 million in nonrecurring funds for each of the next 10 years, beginning in Fiscal Year 2024-2025, for the revolving loan fund created by the bill.

   The bill allows DOH to use up to 3% of the $50 million in nonrecurring funds set aside each year for the revolving loan fund to cover the administrative costs of implementing the revolving loan program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If the program is implemented, loan awardees will be able to pursue innovative health care solutions, which may have a positive economic impact on the recipients and the health care system as a whole.

D. FISCAL COMMENTS:

None.

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 DOH has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 6, 2024, the Health Care Appropriations Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Provides $250,000 in Fiscal Year 2023-2024 to DOH to implement and administer the Health Care Innovation Council;
- Provides $1 million recurring to DOH to administer the Council;
- Provides $50 million each for year for the next 10 years for the revolving loan fund created by the bill; and
- Allows for DOH to use up to 3% of the $50 million in nonrecurring funds set aside each year for the revolving loan fund to cover the administrative costs of implementing the revolving loan program.

This analysis is drafted to the amended bill as passed by the Health Care Appropriations Committee Subcommittee.

A bill to be entitled

An act relating to health care innovation; creating s. 381.4015, F.S.; defining terms; providing legislative intent; creating the Health Care Innovation Council within the Department of Health for a specified purpose; providing for membership, meetings, and conflicts of interest of the council; specifying conflicts of interest with respect to the revolving loan program established under the act; defining the terms "business relationship" and "relative"; specifying duties of the council; requiring the council, by a specified date, to adopt, and update as necessary, a certain document; requiring the council to submit annual reports to the Governor and the Legislature; requiring state agencies and statutorily created state entities to assist and cooperate with the council as requested; requiring the department to provide administrative support to the council; requiring the department to maintain a link to specified information on the homepage of its website; requiring the department to publish specified information on its website; requiring the department to provide technical assistance to certain applicants upon request; requiring the department to establish and administer a revolving loan program for applicants

seeking to implement certain health care innovations in this state; providing for administration of the program; requiring the department to adopt certain rules; specifying eligibility and application requirements; specifying terms, authorized uses, and repayment options for loans; requiring the department to create and maintain a separate account in the Grants and Donations Trust Fund within the department to fund the revolving loan program; providing that funds for the program are not subject to reversion; authorizing the department to contract with a third party to administer the program, including loan servicing, and manage the revolving loan fund; specifying requirements for the contract; requiring the department to publish and update specified information and reports on its website annually; requiring the Office of Economic and Demographic Research and the Office of Program Policy Analysis and Government Accountability to each develop and present an evaluation of the program to the Governor and the Legislature every 5 years beginning on specified dates; specifying requirements for the evaluations; requiring that the offices be given access to all data necessary to complete the evaluation, including confidential data; authorizing the offices to

collaborate on data collection and analysis; requiring the department to adopt rules; providing for future expiration; authorizing the department to adopt emergency rules to implement the act; providing appropriations; authorizing the department to use a specified percentage of appropriated funds for administrative costs to implement the revolving loan program; providing an effective date.

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

Section 1. Section 381.4015, Florida Statutes, is created to read:

381.4015 Florida health care innovation.—

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

(a) "Council" means the Health Care Innovation Council.

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

(c) "Health care provider" means any person or entity licensed, certified, registered, or otherwise authorized by law to provide health care services in this state.

(2) LEGISLATIVE INTENT.—The Legislature intends to harness the innovation and creativity of entrepreneurs and businesses, together with the state's health care system and stakeholders, to lead the discussion and highlight advances and innovations that will address challenges in the health care system as they

develop in real time and transform the delivery and strengthen the quality of health care in Florida. Innovative technologies, workforce pathways, service delivery models, or other solutions that improve the quality of care in measurable and sustainable ways, that can be replicated, and that will lower costs and allow that value to be passed on to health care consumers shall be highlighted for adoption across all neighborhoods and communities in this state.

(3) HEALTH CARE INNOVATION COUNCIL.—The Health Care Innovation Council, a council as defined in s. 20.03, is created within the department to tap into the best knowledge and experience available by regularly bringing together subject matter experts in a public forum to explore and discuss innovations in technology, workforce, and service delivery models that can be exhibited as best practices, implemented, or scaled in order to improve the quality and delivery of health care in this state in measurable, sustainable, and reproducible ways.

(a) *Membership.*—

1. The Lieutenant Governor shall serve as an ex officio, nonvoting member and shall act as the council chair.

2. The council shall be composed of the following voting members, to be appointed by July 1, 2024:

a. One member appointed by the President of the Senate and one member appointed by the Speaker of the House of

Representatives. The appointing officers shall make appointments prioritizing members who have the following experience:

(I) A representative of the health care sector who has senior-level experience in reducing inefficiencies in health care delivery systems;

(II) A representative of the private sector who has senior-level experience in cybersecurity or software engineering in the health care sector;

(III) A representative who has expertise in emerging technology that can be used in the delivery of health care; or

(IV) A representative who has experience in finance or investment or in management and operation of early stage companies.

b. A physician licensed under chapter 458 or chapter 459, appointed by the Governor.

c. A nurse licensed under chapter 464, appointed by the Governor.

d. An employee of a hospital licensed under chapter 395 who has executive-level experience, appointed by the Governor.

e. A representative of the long-term care facility industry, appointed by the Governor.

f. An employee of a health insurer or health maintenance organization who has executive-level experience, appointed by the Governor.

g. A resident of this state who can represent the interest

of health care patients in this state, appointed by the Governor.

3. The chair of the Council of Florida Medical School Deans shall serve as a voting member of the council.

4. The council shall be composed of the following ex officio, nonvoting members:

a. The State Surgeon General.

b. The Secretary of Health Care Administration.

c. The Secretary of Children and Families.

d. The director of the Agency for Persons with Disabilities.

e. The Secretary of Elderly Affairs.

5. Except for ex officio, nonvoting members, the term of all appointees shall be for 2 years unless otherwise specified. However, to achieve staggered terms, the appointees in sub-subparagraphs 2.a.-c. shall serve initial terms of 3 years. The appointees may be reappointed for no more than four consecutive terms.

6. Any vacancy occurring on the council must be filled in the same manner as the original appointment. Any member who is appointed to fill a vacancy occurring because of death, resignation, or ineligibility for membership shall serve only for the unexpired term of the member's predecessor.

7. Members whose terms have expired may continue to serve until replaced or reappointed. However, members whose terms have

expired may not serve longer than 6 months after the expiration of their terms.

8. Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

9. Members may be removed for cause by the appointing entity.

10. Each member of the council who is not otherwise required to file a financial disclosure statement pursuant to s. 8, Art. II of the State Constitution or s. 112.3144 must file a disclosure of financial interests pursuant to s. 112.3145.

(b) *Meetings.*—The council shall convene its first organizational meeting by September 1, 2024. Thereafter, the council shall meet as necessary, but at least quarterly, at the call of the chair. In order to provide an opportunity for the broadest public input, the chair shall ensure that a majority of the meetings held in a year are geographically dispersed within this state. As feasible, meetings are encouraged to provide an opportunity for presentation or demonstration of innovative solutions in person. A majority of the members of the council constitutes a quorum, and a meeting may not be held with less than a quorum present. In order to establish a quorum, the council may conduct its meetings through teleconference or other electronic means. The affirmative vote of a majority of the members of the council present is necessary for any official

action by the council.

(c) *Conflicts of interest.*—

1. A council member may not vote on any matter that would provide:

a. Direct financial benefit to the member;

b. Financial benefit to a relative of the member, including an entity of which a relative is an officer, partner, director, or proprietor or in which the relative has a material interest; or

c. Financial benefit to a person or entity with whom the member has a business relationship.

2. With respect to the revolving loan program established in subsection (7):

a. Council members may not receive loans under the program.

b. A person or entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph 1.b. or sub-subparagraph 1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the person's or entity's application.

3. For purposes of this paragraph, the term:

a. "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited

partnership, limited liability partnership, limited liability company, or other entity or business association.

b. "Relative" means a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law of a person.

(d) *Public meetings and records.*—The council and any subcommittees it forms are subject to the provisions of chapter 119 relating to public records and the provisions of chapter 286 relating to public meetings.

(4) HEALTH CARE INNOVATION COUNCIL DUTIES.—In order to facilitate and implement this section, the council shall:

(a) By February 1, 2025, adopt and update as necessary a document that sets forth and describes a mission statement, goals, and objectives for the council to function and meet the purposes of this section.

(b) Facilitate public meetings across this state at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions on concepts that address challenges to the health care system as they develop in real time and advance the delivery of health care in this state through technology and innovation.

1. Consideration must be given to how such concepts increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve

patient outcomes, expand public access to health care services in this state, or reduce costs for patients and the state without reducing the quality of patient care.

2. Exploration and discussion of concepts may include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payors, patients, and the state.

3. The council may coordinate with the Florida Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business incubators, development organizations, or institutions of higher education to include emerging and early stage innovators, developers, and implementers of technology, models, or solutions in health care in the exploration and discussion of concepts and breakthrough innovations.

4. To support adoption and implementation of innovations and advancements, specific meetings may be held which bring together technical experts, such as those in system integration, cloud computing, artificial intelligence, and cybersecurity, to lead discussions on recommended structures and integrations of information technology products and services and propose solutions that can make adoption and implementation efficient, effective, and economical.

5. The council may also highlight broad community or statewide issues or needs of providers and users of health care

delivery and may facilitate public forums in order to explore and discuss the range of effective, efficient, and economical technology and innovative solutions that can be implemented.

(c) Annually distinguish the most impactful concepts by recognizing the innovators, developers, and implementers whose work is helping Floridians live brighter and healthier lives. In seeking out projects, initiatives, and concepts that are having a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in this state, the council may issue awards to recognize these strategic and innovative thinkers who are helping Floridians live brighter and healthier lives. The council may develop a logo for the award for use by awardees to advertise their achievements and recognition.

(d) Consult with and solicit input from health care experts, health care providers, and technology and manufacturing experts in the health care or related fields, users of such innovations or systems, and the public to develop and update:

1. Best practice recommendations that will lead to the continuous modernization of the health care system in this state and make the Florida system a nationwide leader in innovation, technology, and service. At a minimum, recommendations must be made for how to explore implementation of innovations, how to

implement new technologies and strategies, and health care service delivery models. As applicable, best practices must be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency room visits, and reducing costs for patients and the state without reducing the quality of patient care. Specifically for information technology, best practices must also recommend actions to guide the selection of technologies and innovations, which may include, but need not be limited to, considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training.

2. A list of focus areas in which to advance the delivery of health care in this state through innovative technologies, workforce pathways, or service delivery models. The focus areas may be broad or specific, but must, at a minimum, consider all of the following topics:

a. The health care workforce. This topic includes, but is not limited to, all of the following:

(I) Approaches to cultivate interest and growth in the workforce, including concepts resulting in increases in the number of providers.

(II) Efforts to improve the use of the workforce, whether

through techniques, training, or devices to increase effectiveness or efficiency.

(III) Educational pathways that connect students with employers or result in attainment of cost-efficient and timely degrees or credentials.

(IV) Use of technology to reduce the burden on the workforce during decisionmaking processes such as triage, but which leaves all final decisions to the health care practitioner.

b. The provision of patient care in the most appropriate setting and reduction of unnecessary emergency room visits. These topics include, but are not limited to, all of the following:

(I) Use of advanced technologies to improve patient outcomes, provide patient care, or improve patient quality of life.

(II) The use of early detection devices, including remote communications devices and diagnostic tools engineered for early detection and patient engagement.

(III) At-home patient monitoring devices and measures.

(IV) Advanced at-home health care.

(V) Advanced adaptive equipment.

c. The delivery of primary care through methods, practices, or procedures that increase efficiencies.

d. The technical aspects of the provision of health care.

These aspects include, but are not limited to, all of the following:

(I) Interoperability of electronic health records systems and the impact on patient care coordination and administrative costs for health care systems.

(II) Cybersecurity and the protection of health care data and systems.

(e) Identify and recommend any changes to Florida law or changes that can be implemented without legislative action which are necessary to:

1. Advance, transform, or innovate in the delivery and strengthen the quality of health care in Florida, including removal or update of any regulatory barriers or governmental inefficiencies.

2. Implement the council's duties or recommendations.

(f) Recommend criteria for awarding loans as provided in subsection (7) to the department and review loan applications.

(g) Annually submit by December 1 a report of council activities and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives. At a minimum, the report must include an update on the status of the delivery of health care in this state; information on implementation of best practices by health care industry stakeholders in this state; and highlights of exploration, development, or implementation of innovative technologies,

workforce pathways, service delivery models, or other solutions by health care industry stakeholders in this state.

(5) AGENCY COOPERATION.—All state agencies and statutorily created state entities shall assist and cooperate with the council as requested.

(6) DEPARTMENT DUTIES.—The department shall, at a minimum, do all of the following to facilitate implementation of this section:

(a) Provide reasonable and necessary support staff and materials to assist the council in the performance of its duties.

(b) Maintain on the homepage of the department a link to a website dedicated to the council on which the department shall post information related to the council, including the outcomes of the duties of the council and annual reports as described in subsection (4).

(c) Identify and publish on its website a list of any sources of federal, state, or private funding available for implementation of innovative technologies and service delivery models in health care, including the details and eligibility requirements for each funding opportunity. Upon request, the department shall provide technical assistance to any person wanting to apply for such funding. If the entity with oversight of the funding opportunity provides technical assistance, the department may foster working relationships that allow the

department to refer the person seeking funding to the appropriate contact for such assistance.

(d) Incorporate recommendations of the council into the department's duties or as part of the administration of this section, or update administrative rules or procedures as appropriate based upon council recommendations.

(7) REVOLVING LOAN PROGRAM.—The department shall establish and administer a revolving loan program for applicants seeking to implement innovative solutions in this state.

(a) *Administration.*—The council may make recommendations to the department for the administration of the loans. The department shall adopt rules:

1. Establishing an application process to submit and review funding proposals for loans. Such rules must also include the process for the council to review applications to ensure compliance with applicable laws, including those related to discrimination and conflicts of interest. If a council member participated in the vote of the council recommending an award for a proposal with which the council member has a conflict of interest, the division may not award the loan to that entity.

2. Establishing eligibility criteria to be applied by the council in recommending applications for the award of loans which:

a. Incorporate the recommendations of the council. The council shall recommend to the department criteria based upon

input received and the focus areas developed. The council may recommend updated criteria as necessary, based upon the most recent input, best practice recommendations, or focus areas list.

b. Determine which proposals are likely to provide the greatest return to the state if funded, taking into consideration, at a minimum, the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

3. It deems necessary to administer the program, including, but not limited to, rules for application requirements, the ability of the applicant to properly administer funds, the professional excellence of the applicant, the fiscal stability of the applicant, the state or regional impact of the proposal, matching requirements for the proposal, and other requirements to further the purposes of the program.

(b) *Eligibility.*—

1. The following entities may apply for a revolving loan:

a. Entities licensed, registered, or certified by the Agency for Health Care Administration as provided under s. 408.802, except for those specified in s. 408.802(1), (3), (13), (23), or (25).

b. An education or clinical training provider in partnership with an entity under sub-subparagraph a.

2.a. Council members may not receive loans under the program.

b. An entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph (3)(c)1.b. or sub-subparagraph (3)(c)1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the entity's application.

3. Priority must be given to applicants located in a rural or medically underserved area as designated by the department which are:

a. Rural hospitals as defined in s. 395.602(2).

b. Nonprofit entities that accept Medicaid patients.

4. The department may award a loan for up to 50 percent of the total projected implementation costs, or up to 80 percent of the total projected implementation costs for an applicant under subparagraph 3. The applicant must demonstrate the source of funding it will use to cover the remainder of the total projected implementation costs, which funding must be from nonstate sources.

(c) *Applications.*—

1. The department shall set application periods to apply for loans. The department may set multiple application periods in a fiscal year, with up to four periods per year. The

department shall coordinate with the council when establishing application periods to establish separate priority, in addition to eligibility, within the loan applications for defined categories based on the current focus area list. The department shall publicize the availability of loans under the program to stakeholders, education or training providers, and others.

2. Upon receipt of an application, the department shall determine whether the application is complete and the applicant has demonstrated the ability to repay the loan. Within 30 days after the close of the application period, the department shall forward all completed applications to the council for consideration.

3. The council shall review applications for loans under the criteria and pursuant to the processes and format adopted by the department. The council shall submit to the department for approval lists of applicants that it recommends for funding, arranged in order of priority and as required for the application period.

4. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to fill a demonstrated need; obtain or upgrade necessary equipment, hardware, and materials; adopt new technologies or systems; or a combination thereof which will improve the quality and delivery of health care in measurable

and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

(d) *Awards.*—

1. The amount of each loan must be based upon demonstrated need and availability of funds. The department may not award more than 10 percent of the total allocated funds for the fiscal year to a single loan applicant.

2. The interest rate for each loan may not exceed 1 percent.

3. The term of each loan is up to 10 years.

4. In order to equitably distribute limited state funding, applicants may apply for and be awarded only one loan per fiscal year. If a loan recipient has one or more outstanding loans at any time, the recipient may apply for funding for a new loan if the current loans are in good standing.

(e) *Written agreement.*—

1. Each loan recipient must enter into a written agreement with the department to receive the loan. At a minimum, the agreement with the applicant must specify all of the following:

a. The total amount of the award.

b. The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.

c. The information to be reported on actual implementation costs, including the share from nonstate resources.

d. The schedule for payment.

e. The data and progress reporting requirements and schedule.

f. Any sanctions that would apply for failure to meet performance conditions.

2. The department shall develop uniform data reporting requirements for loan recipients to evaluate the performance of the implemented proposals. Such data must be shared with the council.

3. If requested, the department shall provide technical assistance to loan recipients under the program.

(f) *Loan repayment.*—Loans become due and payable in accordance with the terms of the written agreement. All repayments of principal received by the department in a fiscal year shall be returned to the revolving loan fund and made available for loans to other applicants.

(g) *Revolving loan fund.*—The department shall create and maintain a separate account in the Grants and Donations Trust Fund within the department as a fund for the program. All repayments of principal must be returned to the revolving loan fund and made available as provided in this section. Notwithstanding s. 216.301, funds appropriated for the revolving loan program are not subject to reversion. The department may contract with a third-party administrator to administer the program, including loan servicing, and manage the revolving loan

fund. A contract for a third-party administrator which includes management of the revolving loan fund must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

(8) REPORTING.—The department shall publish on its website information related to loan recipients, including the written agreements, performance conditions and their status, and the total amount of loan funds disbursed to date. The department shall update the information annually on the award date. The department shall, beginning on September 1, 2025, and annually thereafter, post on its website a report on this section for the previous fiscal year which must include all of the following information:

(a) A summary of the adoption and implementation of recommendations of the council during the previous fiscal year.

(b) An evaluation of actions and related activities to meet the purposes set forth in this section.

(c) Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in this section.

(d) The number of applications for loans, the types of proposals received, and an analysis on the relationship between the proposals and the purposes of this section.

(e) The amount of funds allocated and awarded for each

loan application period, as well as any funds not awarded in that period.

(f) The amount of funds paid out during the fiscal year and any funds repaid or unused.

(g) The number of persons assisted and outcomes of any technical assistance requested for loans and any federal, state, or private funding opportunities.

(9) EVALUATION.—

(a) Beginning October 1, 2029, and every 5 years thereafter, the Office of Economic and Demographic Research (EDR) shall develop and present to the Governor, the President of the Senate, and the Speaker of the House of Representatives a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program administered under this section. The evaluation must include, but need not be limited to, separate calculations of the state's return and the economic value to residents of this state, as well as the identification of any cost savings to patients or the state and the impact on the state's health care workforce.

(b) Beginning October 1, 2030, and every 5 years thereafter, the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall develop and present to the Governor, the President of the Senate, and the Speaker of the House of Representatives an evaluation of the administration and efficiency of the revolving loan program administered under this

section. The evaluation must include, but need not be limited to, the degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in paragraph (a) without reducing the quality of patient care.

(c) Both the EDR and OPPAGA shall include recommendations for consideration by the Legislature. The EDR and OPPAGA must be given access to all data necessary to complete the evaluation, including any confidential data. The offices may collaborate on data collection and analysis.

(10) RULES.—The department shall adopt rules to implement this section.

(11) EXPIRATION.—This section expires July 1, 2043.

Section 2. The Department of Health shall, and all conditions are deemed met to, adopt emergency rules pursuant to s. 120.54(4), Florida Statutes, for the purpose of implementing s. 381.4015, Florida Statutes. Notwithstanding any other law, emergency rules adopted pursuant to this section are effective for 6 months after adoption and may be renewed during the pendency of the procedure to adopt permanent rules addressing the subject of the emergency rules.

Section 3. (1) For the 2023-2024 fiscal year, the sum of $250,000 in nonrecurring funds from the General Revenue Fund is appropriated to the Department of Health to implement and

administer the Health Care Innovation Council under s. 381.4015, Florida Statutes.

(2) For the 2024-2025 fiscal year, the sum of $1 million in recurring funds is appropriated from the General Revenue Fund to the Department of Health to implement and administer the Health Care Innovation Council under s. 381.4015, Florida Statutes.

(3) By August 1 of each year, beginning in the 2024-2025 fiscal year through the 2033-2034 fiscal year, the Chief Financial Officer shall transfer the sum of $50 million in nonrecurring funds from the General Revenue Fund to the Grants and Donations Trust Fund within the Department of Health. Each year, beginning in the 2024-2025 fiscal year through the 2033-2034 fiscal year, the sum of $50 million in nonrecurring funds is appropriated from the Grants and Donations Trust Fund to the Department of Health for the revolving loan fund created in s. 381.4015, Florida Statutes. The department may use up to 3 percent of the appropriated funds for administrative costs to implement the revolving loan program.

Section 4. This act shall take effect upon becoming a law.

CS/HB 1549

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1549 Health Care
SPONSOR(S): Health Care Appropriations Subcommittee, Grant
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N	McElroy	Calamas
2) Health Care Appropriations Subcommittee	14 Y, 0 N, As CS	Smith	Clark
3) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

CS/HB 1549 revises or creates numerous provisions of Florida law relating to the state's health care workforce, health care services, health care practitioner licensure and regulation, health care facility licensure and regulation, the Medicaid program, and health-care-related education programs. Specifically, the bill revises:

- The Dental Student Loan Repayment Program (DSLR Program);
- The Florida Reimbursement Assistance for Medical Education (FRAME) Program;
- The Telehealth Minority Maternity Care Program;
- The Statewide Medicaid Residency Program (SMRP); and
- The Access to Health Care Act.

The bill amends statutes relating to:

- Licensure by endorsement for health care practitioners;
- Mobile response team standards;
- Licensure for foreign-trained physicians;
- Certification of foreign medical schools;
- Medical faculty certificates;
- Autonomous-practice nurse midwives;
- Developmental research laboratory schools; and
- The Linking Industry to Nursing Education (LINE) Fund.

The bill creates:

- The Health Care Screening and Services Grant Program;
- An advanced birth center designation;
- The Training, Education, and Clinicals in Health (TEACH) Funding Program;
- Emergency department diversion requirements for hospitals and Medicaid managed care plans;
- A requirement for the Agency for Health Care Administration (AHCA) to produce an annual report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees;"
- Limited licenses for graduate assistant physicians; and
- Temporary certificates for physician assistants (PA) and advanced practice registered nurses (APRN) to practice in areas of critical need.
- Price transparency requirements for hospitals and insurers and medical debt protection for consumers.

The bill provides that Florida will enter into the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact. The bill contains numerous appropriations related to the programs and revisions listed above, as well as for provider reimbursement in the Medicaid program.

The bill provides various appropriations to implement provisions in the bill. The bill will have no impact on local government. *See* Fiscal Comments.

Except as otherwise provided, the bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The term "health care workforce" means a health care professional working in health service settings. Physicians and nurses make up the largest segments of the health care workforce.[1] The United States has a health care professional shortage. As of December 3, 2023, there are 8,544 Primary Care Health Professional Shortage Areas (HPSAs), 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.[2]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and the growth of the U.S. population[3] and the expanded access to health care under the federal Affordable Care Act.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Health Care Shortage Designations

The federal Health Resources and Services Administration (HRSA) designates health care shortage areas in the United States. The two main types of health care shortage areas designated by the HRSA are HPSA and Medically Underserved Areas (MUA).

Health Care Professional Shortage Areas

A HPSA is a geographic area, population group, or health care facility that has been designated by the HRSA as having a shortage of health professionals. There are three categories of HPSA: primary care, dental health, and mental health.[6]

HPSAs can be designated as geographic areas; areas with a specific group of people such as low-income populations, homeless populations, and migrant farmworker populations; or as a specific facility that serves a population or geographic area with a shortage of providers.[7] As of September 30, 2023, there are 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.[8]

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[1] Spencer, Ph.D., M.PH., Emma, Division Director, Division of Public Health Statistics and Performance Management, The Department of Health, *Florida's Physician and Nursing Workforce,* presented in Florida Senate Health Policy Committee meeting Nov. 14, 2023, published Nov. 15, 2023, (on file with the Select Committee on Health Innovation).

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited January 22, 2024).

[3] The U.S. population is expected to increase by 79 million people by 2060, and average of 1.8 million people each year between 2017 and 2060. *See* U.S. *Census Bureau, Demographic Turning Points for the U.S.; Population Projections for 2020 to 2060* (February 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited January 22, 2024).

[4] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), available at https://www.aamc.org/media/54681/download (last visited January 22, 2024).

[5] The nation's 65-and-older population is projected to nearly double in size in coming decades, from 49 million in 2016 to 95 million people in 2060. *See:* U.S. Census Bureau, *U.S. and World Population Clock*, available at https://www.census.gov/popclock/, and U.S. Census Bureau, *U.S. Population Projected to Begin Declining in Second Half of Century* (Nov. 9, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited January 22, 2024).

[6] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 22, 2024).

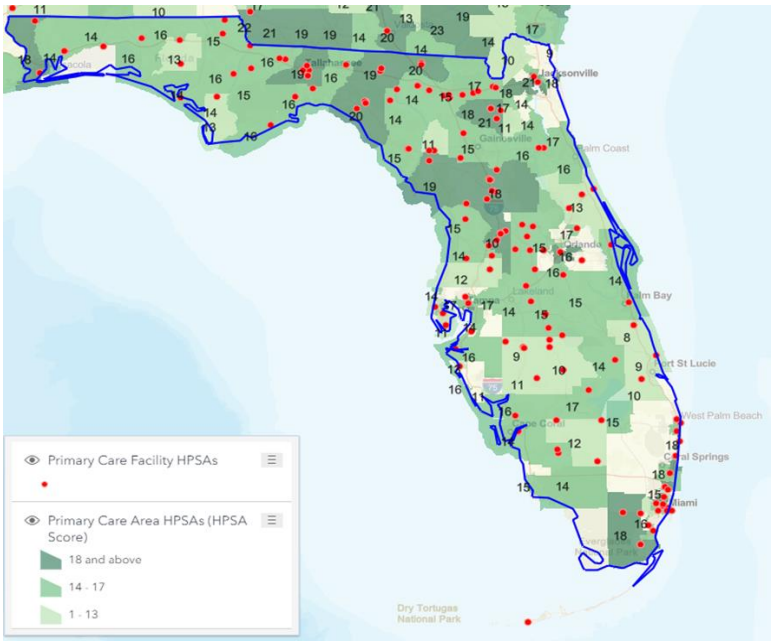
[7] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited January 22, 2024).

[8] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 22, 2024). To generate the report, select "Designated HPSA Quarterly Summary."

Each HPSA is given a score by the HRSA indicating the severity of the shortage in that area, population, or facility. The scores for primary care and mental health HPSAs can be between 0 and 25 and between 0 and 26 for dental health HPSAs, with a higher score indicating a more severe shortage.[9]

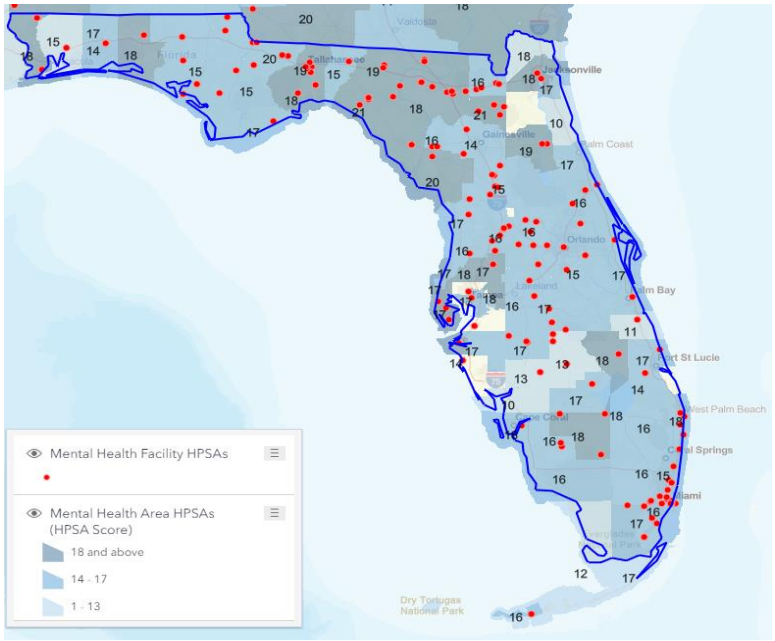
Primary Care HPSAs

Below is a map of primary care HPSAs in Florida with their associated HPSA scores.[10]



Mental Health HPSAs

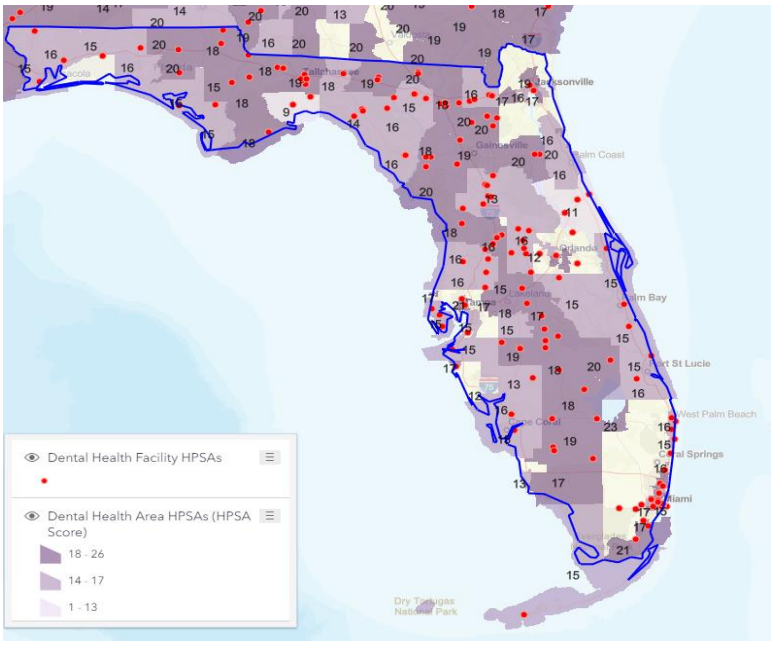
Below is a map of mental health HPSAs in Florida with their associated HPSA scores.



Dental HPSAs

Below is a map of dental health HPSAs in Florida with their associated HPSA scores.

[9] *Scoring Shortage Designations*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring, (last visited January 22, 2024).
[10] The three maps were generated with HRSAs map tool, available at https://data.hrsa.gov/maps/map-tool/, (last visited January 22, 2024).

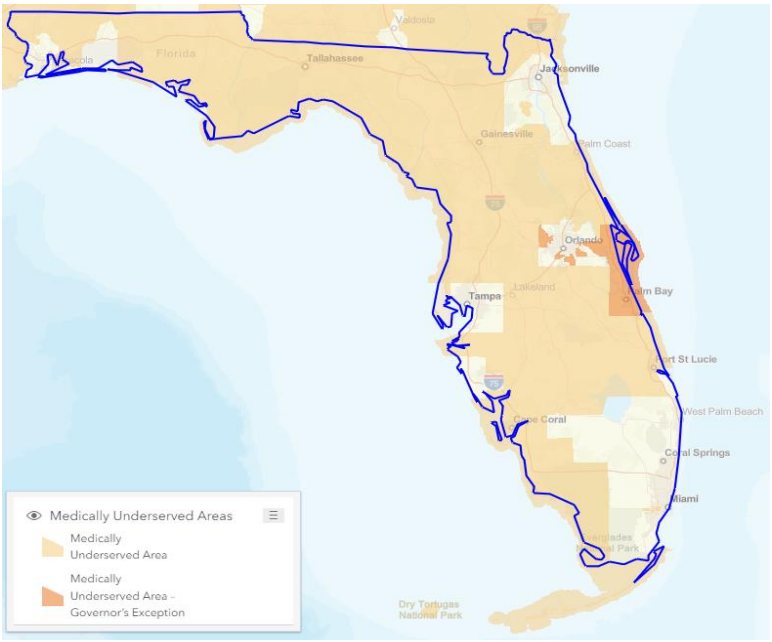


Medically Underserved Areas

MUAs identify an area with a lack of primary care access. MUAs have a shortage of primary care health services within geographic areas such as:

- A whole county
- A group of neighboring counties
- A group of urban census tracts
- A group of county or civil divisions.[11]

Below is a map of the MUAs in Florida.



[11] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw .hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 22, 2024).

The Florida Physician Workforce

In 2020, there were 286.5 physicians actively practicing per 100,000 population in the United States.[12] There were 94,925 total allopathic and osteopathic physicians with an active license in Florida.[13] Of these active physicians, 79,045 or 83.27 percent renewed their medical licenses from July 1, 2021–June 30, 2023, and responded to the statutorily required workforce survey. The Department of Health (DOH) used that survey in preparation of the 2023 Physician Workforce Annual Report, which made the following findings regarding the adequacy of Florida's physician work force providing direct patient care to Floridians:

- Of these physicians, there were 56,769 or 72 percent provide direct patient care. Those who renewed during this survey cycle and responded to the survey, were 87.97 percent allopathic physicians and 12.03 percent osteopathic physicians;
- Statewide, 35.82 percent of Florida's 67 counties have a per capita rate of 10 or fewer physicians per 10,000 population;
- The physician work force survey showed that 98.11 percent of physicians work in urban counties while 1.89 percent work in Florida's 31 rural counties. In all of the rural counties, at least 20 percent of physicians are primary care providers;
- Among physicians, 34.17 percent or 19,396 are age 60 and older;
- For physicians under age 40, the percentage of female physicians is 46.21 percent;

The top three specialty groups for physicians providing direct patient care in Florida are:

- Internal medicine (28.11 percent or 15,724);
- Family medicine (14.64 percent or 8,191); and
- Pediatrics (7.89 percent or 4,413);
- Primary care physicians account for 31.63 percent of physicians providing direct patient care;
- 77.45 percent or 40,132 of physicians practice in an office setting and 20.17 percent or 10,451 practice in a hospital;
- 75.28 percent of physicians report they accept patients with Medicare;
- 64.13 percent of physicians report they accept patients with Medicaid;
- A total of 9.56 percent or 5,429 of physicians providing direct patient care plan to retire in the next five years; and
- Just over 2 percent or 1,181 of physicians practice in Florida's rural counties.[14]

IHS Markit Report – Physician Supply and Demand Deficit

In 2021, IHS Markit prepared a report for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association that examined Florida's statewide and regional physician workforce with projections on workforce changes out to 2035.[15] Between 2019 and 2035, the report estimates that while physician supply will increase by six percent overall and by three percent to four percent for primary care, the demand for physician services in Florida will grow by 27 percent.[16] While there is already supply and demand deficits for physician services (estimated by 2019 numbers to be at 1,977 for primary care and 1,650 for non-primary care), the significant growth in the demand for physician services that may outpace the growth in the physician workforce over the next decade is estimated to create a shortfall of 7,872 in primary care physicians by 2035 and an overall decline in the adequacy for all non-primary care specialties from 95 percent in 2019 to 77 percent in 2035.[17]

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[12] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), prepared for the AAMC by HIS, Ltd., p. viii, available at https://www.aamc.org/media/54681/download (last visited January 22, 2024). This includes both allopathic and osteopathic physicians.

[13] Department of Health, *2023 Florida Physician Workforce Annual Report*, Nov. 1, 2023, available at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/physician-workforce-development-and-recruitment/2023DOHPhysicianWorkforceAnnualReport-FINAL.pdf (last visited January 22, 2024).

[14] *Id.*

[15] Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035: 2021 Update to Projections of Supply and Demand

[16] *Id.* at V.

[17] *Id.* at VI

The following chart details the estimated supply and demand deficits by physician specialty in 2035:[18]

Specialty	Supply	Demand [a]	Supply-Demand	% Adequacy [b]
Primary Care	**22,900**	**30,773**	**-7,872**	**74%**
Traditional Primary Care	**15,440**	**21,413**	**-5,974**	**72%**
Family Medicine	4,261	8,648	-4,387	49%
General Internal Medicine	6,917	7,797	-881	89%
Pediatric Medicine	3,824	3,870	-46	99%
Geriatric Medicine	437	1,097	-660	40%
Emergency Medicine	2,776	4,295	-1,519	65%
General Surgery	2,228	2,111	117	106%
Obstetrics & Gynecology	2,457	2,954	-497	83%
Non-Primary Care	**33,959**	**44,011**	**-10,052**	**77%**
Allergy & Immunology	276	284	-7	97%
Anesthesiology	3,164	3,818	-654	83%
Cardiology	2,644	3,276	-632	81%
Colorectal Surgery	164	234	-70	70%
Dermatology	1,111	1,044	67	106%
Endocrinology	587	834	-247	70%
Gastroenterology	1,284	1,486	-202	86%
Hematology & Oncology	1,654	2,091	-437	79%
Hospital Medicine	1,993	3,427	-1,434	58%
Infectious Diseases	429	1,167	-737	37%
Neonatology	367	454	-87	81%
Nephrology	758	1,272	-514	60%
Neurological Surgery	458	570	-112	80%
Neurology	1,485	1,314	170	113%
Ophthalmology	1,676	1,731	-55	97%
Orthopedic Surgery	1,751	1,961	-209	89%
Other Specialties	1,063	3,223	-2,160	33%
Otolaryngology	850	771	79	110%
Pathology	1,834	1,605	228	114%
Physical Medicine & Rehabilitation	832	1,313	-481	63%
Plastic Surgery	602	849	-247	71%
Psychiatry	2,037	3,267	-1,230	62%
Pulmonology & Critical Care	1,150	1,798	-648	64%
Radiation Oncology	511	715	-204	71%
Radiology	3,623	2,979	644	122%
Rheumatology	446	560	-114	80%
Thoracic Surgery	329	453	-124	73%
Urology	572	1,030	-459	55%
Vascular Surgery	308	485	-176	64%
Florida Total	**56,859**	**74,784**	**-17,924**	**76%**

Source: IHS Markit © 2021 IHS Markit

Note: [a] Demand is estimated based on national patterns of healthcare use and delivery applied to the population in Florida and controlling for differences in demographics, disease prevalence, health risk behavior, health insurance, and household income. [b] Adequacy is calculated as supply divided by demand, and indicates whether supply is sufficient to provide a level of care consistent with the national average in 2019.

The Florida Nursing Workforce

During the 2020-2021, license renewal cycle, Florida was home to 441,361 active nursing licenses made up of 69,511 LPN; 326,669 RN; and 45,181 APRN licenses. Licensees held either single-state or multi-state licenses. Multi-state licenses made up 19.6 percent of LPN licenses, 22.2 percent of RN licenses, and 16.9 percent of APRN licenses. There were 366,235 nurses in Florida (83 percent) that responded to the FCN Nursing Workforce Survey.[19]

The median age of nurses was 46 for RNs, 48 for LPNs, and 45 for APRNs. The table below provides a comparison of the ages of the LPNs, RNs, and APRNs that make up Florida's nursing workforce to the U.S. nursing workforce and state and U.S. census data.[20]

Age	FL LPNs	FL RNs	FL APRNs	FL NURSES	U.S. NURSES	Florida	United States
29 or younger	12.5%	14.8%	5.2%	11.2%	10.9%	33.7%	38.3%
30 - 39	21.8%	24.3%	31.5%	24.6%	24.2%	12.9%	13.6%
40 - 49	22.2%	20.6%	27.8%	21.5%	21.8%	12.1%	12.4%
50 - 59	22.3%	20.3%	21.1%	21.1%	21.4%	13.3%	12.9%
60 or older	21.1%	20.1%	14.4%	21.6%	21.7%	27.9%	22.8%

[18] *Id.* at 10

[19] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited January 22, 2024).

[20] *Id.*

The Florida Department of Economic Opportunity develops a *College Projections Report* that includes the *Fastest Growing Occupations between 2020 and 2028*. APRN is the fastest growing profession. The report also includes the occupations gaining the most new jobs between 2020 and 2028, and RNs are number seven.[21] The number of jobs for LPNs in Florida decreased by 12.19 percent between 2012 and 2021,[22] but LPN jobs have a projected growth of 5,197 jobs (12.6 percent) from 2022-2030 with a total of 31,747 job openings over the eight-year period.[23]

There were 45,181 APRNs licensed on Florida as of the 2020-2021 license renewal. Of those 7,691 (17 percent) are Autonomous APRNs. Thirty-four percent of APRNs work in physician's offices while most autonomous APRNs practice in the area of adult and family health (50.1 percent).[24]

Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act

Heath Care Practitioner Licensure and Regulation

The Division of Medical Quality Assurance (MQA), within the DOH, has general regulatory authority over health care practitioners.[25] The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions.[26] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

The self-stated purpose of the MQA is to protect health care consumers.[27] Regulation of health care licensure broadly aids the consumer in differentiating the trained from the untrained and enhancing public health initiatives.[28] Through licensure regulation, the state is able to establish a minimum standard of education and experience necessary for a person to practice a particular profession and ensure a minimum standard of care through enforcement mechanisms which may result in action against a professional's license.[29]

The MQA is statutorily responsible for the following boards and professions established within the division:[30]

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;

[21] The Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research, 2020 - 2028 Employment Projections, updated Feb. 9, 2021, *2020 - 2028 College Projections Report,* available at https://lmsresources.labormarketinfo.com/college_projections/index.html (last visited January 22, 2024).
[22] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited January 22, 2024).
[23] Florida Commerce, Bureau of Workforce Statistics and Economic Research, *Occupational Data Search, 29-2061 Licensed Practical or Vocational Nurses*, available at https://floridajobs.org/economic-data/employment-projections/occupational-data-search (last visited January 22, 2024).
[24] Florida Center for Nursing, *Florida Autonomous Practice 2020-2021*, available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1975&PortalId=0&TabId=151 (last visited January 22, 2024).
[25] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[26] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2022-2023*. Available at https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/annual-reports.html (last visited January 22, 2024)
[27] *Id*.
[28] Adams, T.L. (2020). *Health professional regulation in historical context: Canada, the USA and the UK (19th century to present)*. Hum Resour Health 18, 72. https://doi.org/10.1186/s12960-020-00501-y
[29] Section 456.072(2), F.S.; *see also, supra* note **Error! Bookmark not defined.**.
[30] Section 456.001(4), F.S; *see also supra* note **Error! Bookmark not defined.**.

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

DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. DOH receives and investigates complaints about practitioners, and prosecutes cases for disciplinary action against practitioners.[31] The boards determine the course of action and any disciplinary action to take against a practitioner.[32] For professions in which there is no board, DOH determines the action and discipline to take against a practitioner and issues the final orders.[33] DOH is responsible for ensuring that licensees comply with the terms and penalties imposed by the boards.[34]

Pathways to Licensure

Licensure by examination is the most common pathway for individuals seeking initial licensure, particularly among health care professionals educated and trained in Florida. The requirements to qualify for licensure by examination are specified in each profession's respective practice act and vary based on professional standards. However, licensure by examination generally requires, at a minimum, the following from applicants:

- Completion of an approved[35] educational program;
- Completion of an approved[36] licensure or certification examination with a passing score; and
- Submission of an application approved by DOH in conjunction with an application fee.

Licensure by endorsement is the most common alternative to licensure by examination. Licensure by endorsement is an expedited licensure process which allows a health care professional to become licensed in one state based upon holding a substantially equivalent health care professional license in another state.

[31] Section 456.072(2), F.S.
[32] Section 456.072(2), F.S.
[33] *Id.* Professions which do not have a board include naturopathy, nursing assistants, midwifery, respiratory therapy, dietetics and nutrition, electrolysis, medical physicists, and school psychologists.
[34] Department of Health, *Prosecution Services*. Available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited January 22, 2024).
[35] The requirements for "approval" of an educational program or examination vary by profession; some practice acts outline specific qualifications such as accreditation with a national board, while others grant the relevant regulatory board discretion in determining such requirements.
[36] *Id.*

Currently, only 20 of the health care professions regulated by DOH and the boards authorize licensure by endorsement.[37]

Professions With Licensure by Endorsement	Professions Without Licensure by Endorsement
Acupuncturist	Anesthesiologist Assistant
Allopathic Physician (MD)	Athletic Trainer
Audiologist	Chiropractor
Certified Nursing Assistant (CNA)	Clinical Laboratory Personnel
Mental Health Professions	Dental Hygienist
Dietitian	Dentist
Electrologist	EMT/Paramedic
Licensed Practical Nurse	Genetic Counselor
Massage Therapist	Hearing Aid Specialist
Midwifery	Medical Physicist
Nursing Home Administrator	Optometrist
Occupational Therapist	Optician
Pharmacist	Orthotist and Prosthetist
Physical Therapist	Osteopathic Physician (DO)
Physical Therapist Assistant	Physician Assistant
Psychologist	Podiatrist
Radiation Technician	Registered Pharmacy Technician
Registered Nurse (RN/APRN)	
Respiratory Therapist	
Speech-Language Pathologist	

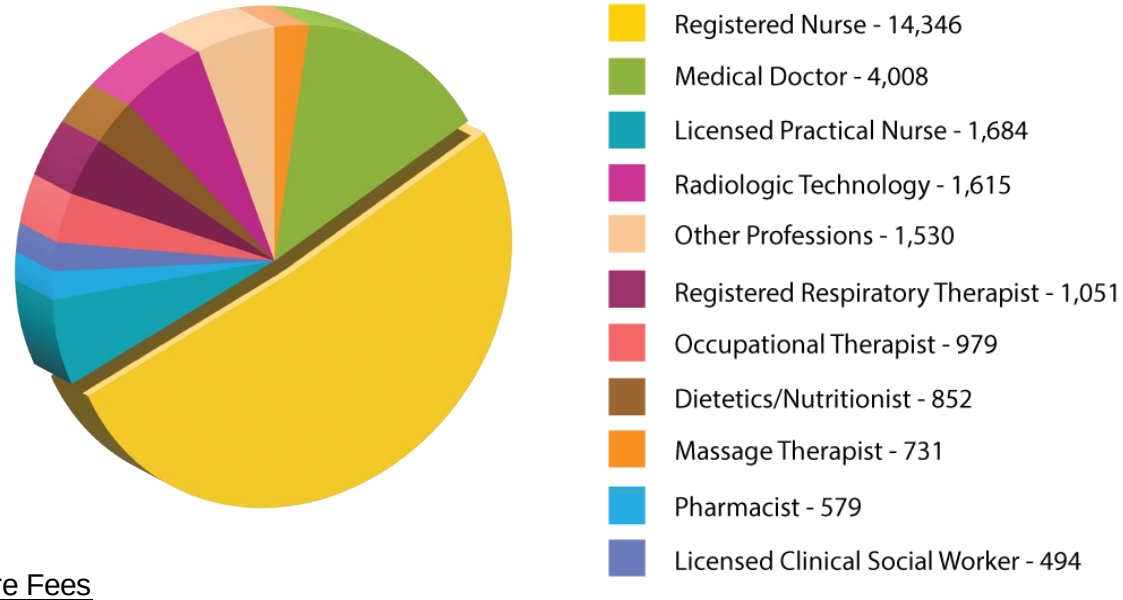
Even amongst the professions which allow licensure by endorsement there are no standard requirements. Rather, requirements to obtain licensure by endorsement vary greatly by profession. For example, some professions require that the applicant submit to a background screening,[38] have a certain amount of prior practice experience,[39] or pass an exam on Florida rules and laws relevant to the profession[40].

[37] Email from Jennifer Wenhold, Division of Medical Quality Assurance Director, Florida Department of Health, RE: Endorsement Info, July 13, 2023. On file with the Health and Human Services Committee.
[38] Allopathic Physicians, Certified Nursing Assistants, Licensed Practice Nurses, Registered Nurses, and Massage Therapists.
[39] Allopathic Physicians, Mental Health Professionals, Licensed Practical Nurses, Registered Nurses, Nursing Home Administrators, Pharmacists, and Psychologists.
[40] Mental Health Professions, Licensed Practical Nurses, Registered Nurses, Nursing Home Administrators, Pharmacists, Psychologists, and Radiology Technicians.

From FY 18-19 to FY 22-23 DOH approved 136,533 licenses by endorsement.[41] During that time DOH reduced the average business days to issue such licenses from 2.5 days to 1.4 days.[42]

Fiscal Year	Total Licenses by Endorsement	Avg Business Days to Issue License
FY 18-19	21,492	2.495
FY 19-20	21,841	2.091
FY 20-21	29,258	1.450
FY 21-22	36,073	1.380
FY 22-23	27,869	1.379
Overall	**136,533**	**1.672**

In FY 2022-23 DOH approved 27,869 applications for licensure by endorsement for the various professions listed below.[43]



Licensure Fees

Health care practitioner regulation is typically funded through fees paid during the licensure process. Current law expressly states that all costs of regulating health care professions and practitioners are to be borne solely by licensees and licensure applicants.[44] Such fees should be reasonable and not serve as a barrier to licensure.

Section 456.025(3), F.S., directs the regulatory boards, or DOH if there is no board, to establish by rule license fee amounts for the profession it regulates and ensure that such fees are adequate to cover all anticipated expenses relating to the board and maintain a reasonable cash balance. Fees are to be based upon long-range estimates prepared by the Department of the Revenue required to implement laws relating to the regulation of professions by the department and the board.

Current law specifies that licensure renewal fees established by rule must be:[45]

- Based on revenue projections prepared using generally accepted accounting procedures;

[41] Correspondence from Department of Health to Health and Human Services Committee staff dated 8/11/23 on file with the Health and Human Services Staff.
[42] *Id.*
[43] Florida Department of Health presentation to the Health Care Regulation Subcommittee on November 16, 2023.
[44] Section 456.025, F.S.
[45] Section 456.025(1), FS. Such fees are subject to challenge pursuant to Ch. 120, F.S.

- Adequate to cover all expenses relating to that board identified in the department's long-range policy plan;
- Reasonable, fair, and not serve as a barrier to licensure;
- Based on potential earnings from working under the scope of the license; and
- Similar to fees imposed on similar licensure types.

The fees may not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium.

Effect of bill - Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act

The bill repeals existing licensure by endorsement statutes and establishes a single standardized process for licensure by endorsement for all health care professions regulated by DOH, not just the 20 that currently allow it. The bill requires applicants seeking licensure by endorsement to submit an application and meet the following requirements:

- Hold an active, unencumbered license with a similar scope of practice[46] in a US jurisdiction;
- Have obtained a passing score on a national licensure examination or national certification, if the profession requires such;
- Have actively practiced the profession for two of the last four years;
- Attest that they are not currently subject to a disciplinary hearing for any offense related to the profession for which they are applying for licensure in any US jurisdiction, nor has had disciplinary action taken against their license in the five years preceding application;
- Meet the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure; and
- Submit a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

Under the bill, a person is ineligible for licensure under this section if they:

- Have a complaint, allegation, or investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;
- Have been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Have had a health care provider license revoked or suspended from another of the United States, the District of Columbia, or a United States territory or has voluntarily surrendered any such license;
- Have been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank.

The bill gives the regulatory boards, or DOH if there is no board, the authority to revoke a license issued under this section upon a finding that the individual provided false or misleading material information in an application for licensure.

The bill requires that the regulatory board, or DOH if there is no board, issue a license under this section within 7 days after receipt of all required documentation for the application.

The bill authorizes the regulatory board, or DOH if there is no board, to require the applicant complete a jurisprudence exam specific to Florida state laws and rules as a condition of licensure if such an exam is required by ch. 456, F.S., or the relevant practice act.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill requires DOH submit an annual report to the Governor, the President of the Senate, and the Speaker of the House, providing the following information:

[46] The bill defines "scope of practice" to mean the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license.

- The number of applications for licensure received under this section, distinguished by profession.
- The number of licenses issued under this section.
- The number of applications submitted under this section which were denied and the reason for such denials.
- The number of complaints, investigations, or other disciplinary actions taken against health care practitioners who are licensed under this section.

The bill directs the regulatory boards and DOH to adopt rules necessary to implement these provisions by December 1, 2024.

Interstate Compacts

An interstate compact is a legal contractual agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[47] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[48]

To join a compact, states must enact compact legislation and meet the requirements of the compact. Florida is a party to multiple interstate health care compacts, including the Nurse Licensure Compact,[49] Professional Counselors Licensure Compact,[50] and the Psychology Interjurisdictional Compact.[51]

Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[52] or a registered out-of-state-health care provider is authorized to provide health care services to Florida patients via telehealth.[53] Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under current law, in-state and out-of-state licensed or registered health care practitioners may use telehealth to provide health care services to patients physically located in Florida.[54] The law does not allow health care practitioners to use telehealth to provide services to out-of-state patients.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [55]

Current law partially waives sovereign immunity, allowing individuals to sue state government and its subdivisions.[56] Individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . . . " Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

[47] National Center for Interstate Compacts, *What Are Interstate Compacts?,* https://compacts.csg.org/compacts/ (Last visited January 22, 2024).
[48] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[49] Section 464.0095, F.S.
[50] Section 491.017, F.S.
[51] Section 490.0075, F.S.
[52] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[53] Section 456.47(4), F.S.
[54] Section 456.47(1) and (4), F.S.
[55] Fla. Const. art. X, s. 13.
[56] Section 768.28, F.S.

Impaired Practitioner Program

The impaired practitioner treatment program was created 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.[57] 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.[58] By rule, DOH designates the approved program by contract with a consultant to initiate intervention, recommend evaluation, refer impaired practitioners to treatment providers, and monitor the progress of impaired practitioners. The impaired practitioner program may not provide medical services.[59]

Audiology and Speech-Language Pathology Interstate Compact

Speech-Language Pathology and Audiology Licensure in Florida

The Board of Speech-Language Pathology and Audiology (SLPA Board) within the DOH oversees the licensure and regulation of speech-language pathologist and audiologist in Florida.[60] DOH must issue a license to any applicant whom the Board certifies is qualified to practice speech-language pathology or audiology and who has paid the initial licensure fee.[61]

To receive license to practice speech-language pathology, an individual must meet the following requirements:[62]

- Received a master's or doctoral degree with a major emphasis in speech-language pathology from an institution accredited by:
  - An agency recognized by the Council for Higher Education Accreditation;
  - The U.S. Department of Education or its successor;
  - An institution that is a member in good standing with the Association of Universities and Colleges of Canada; or
  - From an institution outside of the U.S. or Canada that has been determined to be equivalent to an accredited U.S. institution;
- Completed 300 clock hours of supervised clinical experience with at least 200 hours in the area of speech-language pathology;
- Completed nine months of professional employment experience, or its part-time equivalent; and
- Passage of the national examination (Praxis Exam) within three years prior to the date of application.

To receive license to practice audiology, an individual must meet the following requirements:[63]

- Received a doctoral degree with a major emphasis in audiology from an institution accredited by;
  - An agency recognized by the Council for Higher Education Accreditation or its successor;
  - The U.S. Department of Education;
  - An institution that is a member in good standing with the Association of Universities and Colleges of Canada; or
  - From an institution outside of the U.S. or Canada that has been determined to be equivalent to an accredited U.S. institution;
- Completed 300 clock hours of supervised clinical experience with at least 200 hours in the area of audiology;

[57] 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.
[58] Section 456.076(1), F.S.
[59] Rule 64B31-10.001(1)(a), F.A.C.
[60] Section 468.1135, F.S.
[61] *Id.*
[62] Section 468.1185. F.S., and Florida Board of Speech-Language Pathology & Audiology, *Speech-Language Pathologist*, at https://floridasspeechaudiology.gov/licensing/speech-language-pathologist/, (last visited January 22, 2024).
[63] Section 468.1185. F.S., and Florida Board of Speech-Language Pathology & Audiology, *Audiologist*, at https://floridasspeechaudiology.gov/licensing/audiologist/, (last visited January 22, 2024).

- Completed eleven months of clinical experience or one-year clinical work experience within the doctoral program; and
- Passage of the Praxis exam within the three years prior to the date of application.

Audiology and Speech-Language Pathology Interstate Compact

The Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC or compact) is mutual recognition licensure compact that allows an audiologist or speech-language pathologists who holds a license in their home state to apply for a "compact privilege" to practice in another state.[64] Compact privilege also authorizes an audiologist or speech-language pathologist licensed by a home state to practice telehealth in member states. To exercise compact privilege under the ASLP-IC, the audiologist or speech-language pathologist must:

- Hold an active license in the home state (for purposes of compact privilege, the licensee may only hold one home state license at a time);
- Be eligible for compact privilege in any member state;
- Have no encumbrance on any state license;
- Have no adverse actions taken against the license or compact privilege within the previous two (2) years;
- Pay any applicable fees, including any state fee, for the compact privilege;
- Function within the laws and regulations of the remote state when providing services in such state; and
- Report to the ASLP-IC Commission any adverse action taken against his or her license by any non-member state within 30 days from the date the adverse action is taken.

If the home state license is encumbered, the licensee shall lose the compact privilege in all remote states until the home state is no longer encumber and two (2) years have passed since the adverse action.

Under the compact, the privilege to practice is renewable upon the renewal of the home state license.

State Participation in the Audiology and Speech-Language Pathology Interstate Compact

To participate in the ASLP-IC states must implement procedures for considering the criminal history records (background screening) of applicants for the initial privilege to practice.[65] These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information.

Each member state must require an applicant to obtain or retain a license in the home state and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other applicable state laws. Applicants for licensure to meet the following requirements:

For licensure as an audiologist the applicant must:

- Have graduated with a master's or doctoral degree (on or before December 31, 2007) or with a doctoral degree (on or after January 1, 2008) in audiology, or an equivalent degree regardless of degree name, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the U.S Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or
    - Have graduated from an audiology program that is housed in an institution of higher education outside of the United States and:

[64] The ASLP-IC defines "compact privilege" as the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its laws and rules. *Id.*

[65] Under the compact, the initial privilege to practice is granted when a licensed audiologist or speech-language pathologist completes the necessary steps to gain eligibility to apply for the privileges to practice under the compact. These steps are completed by the licensee's home state, and include verifying the applicant's education, examination record, and criminal history record. ASLP-IC, Frequently Asked Questions, at https://aslpcompact.com/wp-content/uploads/2023/10/ASLP-IC-Frequently-Asked-Questions-10-7-23.pdf, (last visited January 22, 2024).

        - For which the program and institution have been approved by the authorized accrediting body in the applicable country; and
        - The degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed supervised clinical practicum experience from an accredited educational institution or its cooperating programs as required by the board;
- Passed a national examination approved by the compact's commission;
- Hold an active, unencumbered license;
- Have not be convicted or found guilty, or have entered into an agreed disposition, of a felony related to the practice of audiology, under applicable state or federal criminal law; and
- Have a valid United States Social Security or National Practitioner Identification number.

For licensure as a speech-language pathologist the applicant must:

- Have graduated with a master's degree from a speech-language pathology program that is accredited by an organization recognized by the U.S. Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or
    - Have graduated from a speech-language pathology program that is housed in an institution of higher education outside of the United States and;
        - For which the program and institution have been approved by the authorized accrediting body in the applicable country; and
        - The degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed a supervised clinical practicum experience from an educational institution or its cooperating programs as required by the ASLP-IC commission;
- Have completed supervised postgraduate professional experience as required by the ASLP-IC commission;
- Passed a national examination approved by the compact's commission;
- Hold an active, unencumbered license;
- Have not be convicted or found guilty, or have entered into an agreed disposition, of a felony related to the practice of speech-language pathology, under applicable state or federal criminal law;
- Have a valid United States Social Security or National Practitioner Identification number.

Audiology and Speech-Language Pathology Compact Commission

The compact establishes the Audiology and Speech-Language Compact Commission (Commission) which is responsible for establishing rules and enforcing the compact. Commission membership consist of compact member states. The licensing board of each member state must delegate two (2) members, one audiologist and one speech-language pathologist, to serve on the Commission. Delegates must be current members of the state licensing board. Each delegate is granted one vote in regard to the promulgation of rules and creation of bylaws and must have the opportunity to participate in the business and affairs of the Commission. The compact requires the Commission to establish and elect an executive committee to act on behalf of, and within the powers granted to them by the Commission.

All Commission and executive committee meetings must be open to the public and public notice of the meeting must be provided. However, the Commission or the executive committee or other committees of the Commission may convene in a closed, non-public meeting if confidential or privileged information must be discussed. Nothing in the compact shall be construed to be a waiver of sovereign immunity.

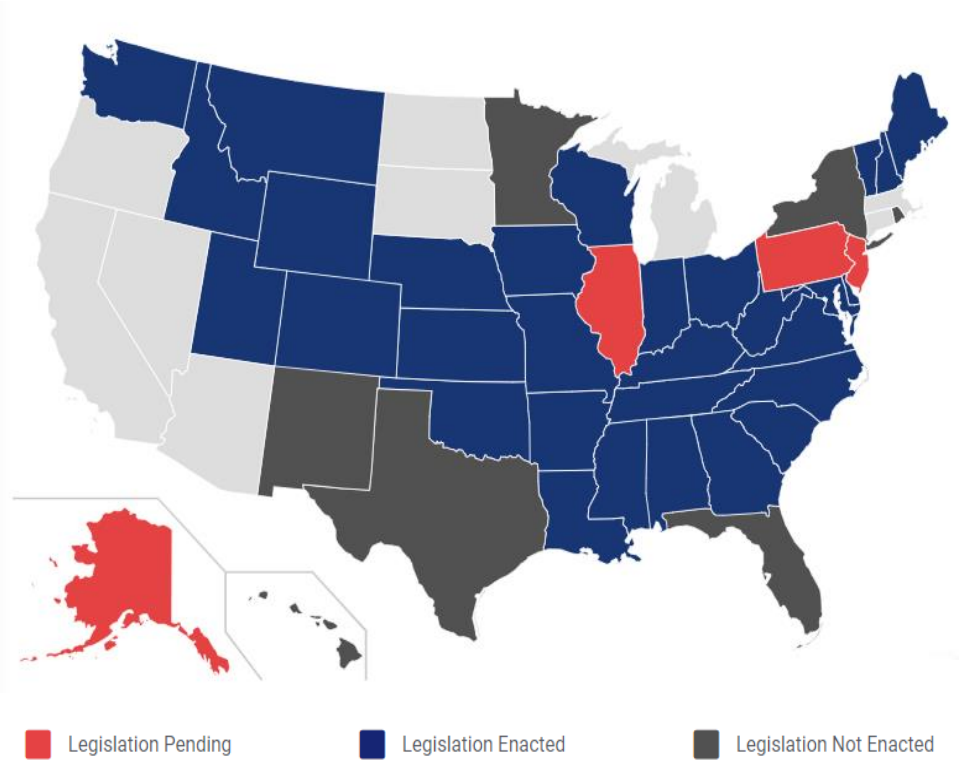
Shared Data System

The compact requires the Commission to develop and maintain a coordinated database and reporting system containing certain information on all licensed individuals in member states. Member states must submit licensure information to the data system for all audiologists and speech-language pathologists to whom the compact applies, including, identifying information, licensure data, and any adverse actions taken against the provider's license. The shared data system will allow for the expedited sharing of adverse action against the license of compact audiologists and speech-language

pathologists.[66] A member state contributing information to the data system may designate information that may not be shared with the public without the express permission of that member state.

Enactment of the Compact

The compact became effective on the date of enactment in the tenth compact state which occurred on April 1, 2021.[67] ASLP-IP currently has 29-member states. The compact is in the process of establishing the commission and operationalizing the compact. The compact anticipate it will begin accepting applications for compact privilege in early 2024.



Effect of the bill - Audiology and Speech-Language Pathology Interstate Compact

The bill requires Florida to join the Audiology and Speech-Language Pathology Interstate Compact. The bill authorizes eligible licensed Florida audiologists and speech-language pathologists to obtain a compact privilege to provide services to out-of-state patients in person or through telehealth in compact member states. It also allows out-of-state licensed audiologists and speech-language pathologists in member states with a Florida compact privilege to provide services to Floridians via telehealth and in-person.

The bill amends current law to allow compact implementation. The bill requires the SLPA Board to implement procedures for background screening, including the submission of fingerprints or other biometric-based information, of applicants applying for licensure for the purpose of obtaining the applicant's criminal history information. The bill also requires the SLPA Board to submit certain specified information on all licensed audiologists and speech-language pathologists practicing under the compact to a shared data system, including, identifying information, licensure data, and any adverse actions taken against the audiologist or speech-language pathologist's license. It requires audiologists and speech-language pathologists to withdraw from all practice under the compact if the audiologist or speech-language pathologist is in an impaired practitioner program. The bill also exempts out-of-state licensed audiologists and speech-language pathologists who practice under the compact

[66] ASLP-IC, *Section-by-Section Overview*, at https://aslpcompact.com/wp-content/uploads/2019/09/90792-ASLP-IC-Section-Flyer_Final.pdf, (last visited January 22, 2024).
[67] American Speech-Language-Hearing Association, *Nebraska Becomes the Critical 10th State to Adopt the Interstate Compact,* at https://www.asha.org/news/2021/nebraska-becomes-10th-state-to-adopt-compact/, (last visited January 22, 2024).

from licensure requirements in this state. Further, the bill authorizes the SLPA Board to take adverse action against a licensed audiologist or speech-language pathologist's privilege to practice under the compact and impose disciplinary actions for violation of prohibited acts.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill preserves the regulatory authority of the state's current system of state licensure and does not require changes to Florida's licensure and license renewal requirements.

Interstate Medical Licensure Compact

Licensure of Florida Physicians

The regulation of the practices of medicine and osteopathic medicine in Florida fall under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[68] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[69]

Licensure by Examination

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:[70]

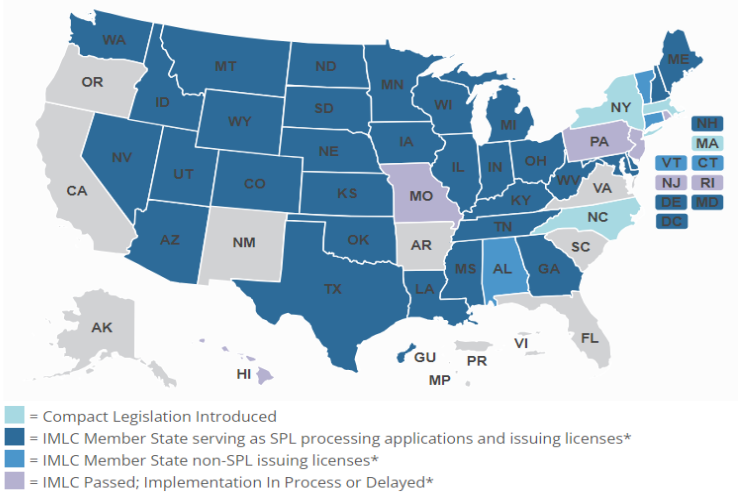
- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education.
- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.
- Demonstrate that she or he has successfully completed an internship or residency (osteopathic) or supervised clinical training (medical) of not less than 12 months in an accredited program (osteopathic) or hospital (medical) approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.

[68] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[69] *Id.*
[70] Sections 458.311 and 459.0055, F.S.

The current licensure application fee for a medical doctor is $350 and is non-refundable.[71] Applications must be completed within one year. If a license is approved, the initial license fee is $355. For osteopathic physicians, the current application fee is non-refundable $200, and if approved, the initial licensure fee is $305.[72] The same application validity provision of one year applies and the processing time of two to six months is the range of time that applicants should anticipate for a decision.[73]

The Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (Medical Licensure Compact or compact) creates an expedited path to licensure by setting qualifications for licensure and outlining a process for physicians to apply and receive licenses in states where they are not currently licensed.[74] Thirty-seven states, the District of Columbia, and the Territory of Guam have adopted the compact.[75]

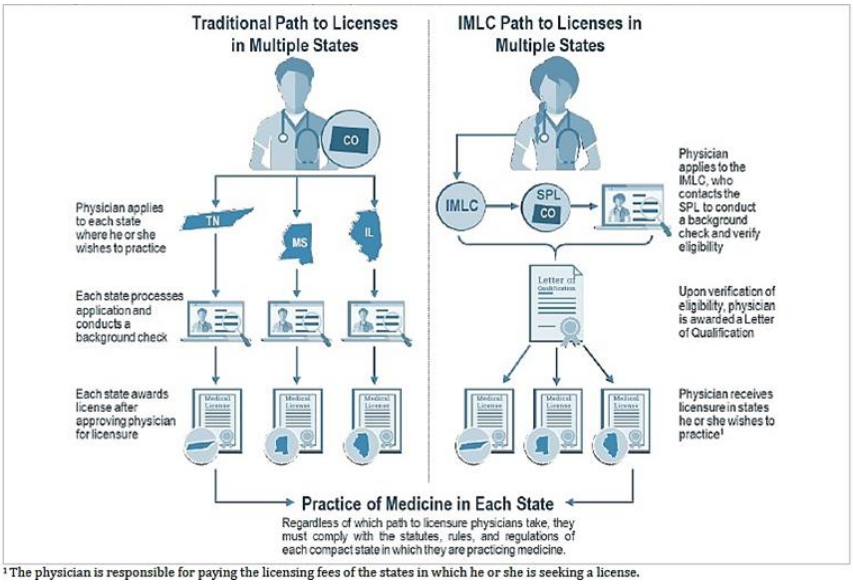


Physician Licensure under the Compact

Typically, if a physician wishes to be licensed in more than one state, the physician must separately apply to each state. The physician must submit documentation to verify qualification for licensure prior to the state issuing a license. However, under the compact the physician must designate a member state as his or her home state or state of principal licensure (SPL)[76] and file an application for an expediated license[77] with the member board (state licensing agency) of the SPL. The SPL verifies the physician's qualifications for licensure by collecting and reviewing all required documents related to training and education and performing a background screening.[78] If the physician meets the required compact qualifications, the SPL will issue a Letter of Qualification. The physician may then submit the Letter of Qualification, along with applicable fees, to the states in which the physicians wishes to be licensed.[79] The Letter of Qualification is valid for 365 days.[80]

[71] Florida Board of Medicine, *Medical Doctor - Fees,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited January 22, 2024).
[72] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/#tab-fees, (last visited January 22, 2024).
[73] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/#tab-process, (last visited January 22, 2024).
[74] *Id.*
[75] Interstate Medical Licensure Compact, *The IMLC*, available at https://www.imlcc.org/participating-states/, (last visited January 22, 2024).
[76] The compact defines the "state of principal license" as a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.
[77] The compact defines "expediated license" as a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.
[78] Interstate Medical Licensure Compact, *About*, available at https://www.imlcc.org/a-faster-pathway-to-physician-licensure/, (last visited January 22, 2024).
[79] *Id.*
[80] Rule 5.6 of the IMLCC Rules, available at https://www.imlcc.org/wp-content/uploads/2023/11/IMLCC-Rule-Chapter-5-Expedited-Licensure-Amended-November-14-2023-FINAL.pdf, (last visited January 22, 2024).

Licensure under the Compact[81]



[1] The physician is responsible for paying the licensing fees of the states in which he or she is seeking a license.

To be eligible to receive a license under the compact, a physician must hold a full unrestricted medical license in a compact member state that can be declared the physician's SPL. To designate a state as a SPL, the physician must ensure that at least one of the following apply:

- The physician's primary residence is in the SPL;
- At least 25% of the physician's practice of medicine occurs in the SPL;
- The physician is employed to practice medicine by a person, business or organization located in the SPL; or
- The physician uses the SPL as his or her state of residence for U.S. Federal Income Tax purposes.

The physician must also meet the following requirements to be licensed under the compact:

- Have graduated from a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;
- Have passed each component of the United States Medical Licensing Exam (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMPLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;
- Have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
- Hold a specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic Specialties; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the expedited Compact process;
- Possess a full and unrestricted license to engage in the practice of medicine issued by a member board;[82]
- Have never been convicted received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

[81] Office of Program Policy Analysis and Gov't Accountability, Florida Legislature, *Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts*, Report No. 19-07, (Oct. 1, 2019) available at https://oppaga.fl.gov/Documents/Reports/19-07.pdf, (last visited January 22, 2024).

[82] The compact defines "member board" as the state agency in the member state that acts in the sovereign interest for the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. Under the compact, DOH would be the member board in Florida.

- Have never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;
- Have never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and
- Not be under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

A physician who does not meet the above-listed criteria may still obtain a non-compact license from a member state if the physician meets the requirements to practice in that state.

Upon completion of eligibility verification process by the compact member state, applicants suitable for an expedited license are directed to complete the registration process with the Interstate Medical Licensure Compact Commission (Commission), including the payment of any fees. After completing the registration process and paying the appropriate fees, the member board will issue an expedited license to the physician. The license authorizes the physician to practice medicine in the issuing state consistent with the laws and regulations of the issuing member board and member state.

An expedited license is valid for a period consistent with the member state licensure period and in the same manner as required for other physicians holding a full and unrestricted license. The expedited license must be terminated if a physician fails to maintain a license in the SPL for a non-disciplinary reason, without re-designation of a new SPL.

The compact authorizes the Commission to adopt rules regarding the application process, including the payment of any applicable fees, and the issuance of an expedited license. The compact also gives states issuing an expediated license authorizing physicians to practice in the compact the discretion to impose fees for licensure or renewal through the compact. However, the compact does not authorize DOH to collect a fee, but rather states that fees of this kind are allowable under the compact.

License Renewal and Continued Compact Participation

The compact requires the member board to notify a physician at least 90 days prior to the expiration of a license issued through the compact.[83] To renew a compact license the physician must:

- Maintain a full and unrestricted license in a SPL;
- Not have been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- Not have had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action relating to non-payment of fees related to a license; and
- Not have had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement Administration.

Physicians must also comply with all continuing education and professional development requirements for renewal of a license issued by a member state.

The Commission collects any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician's license may be renewed. Any information collected during the renewal process shall also be shared with all member boards.

Interstate Medical Licensure Compact Commission

The compact establishes the Interstate Medical Licensure Compact Commission to oversee and maintain the administration of the compact. The Commission has all the duties, powers, and responsibilities set forth in the compact, plus any other powers conferred upon it by the member states

[83] Rule 5.8 of the IMLCC Rules, available at https://www.imlcc.org/wp-content/uploads/2023/11/IMLCC-Rule-Chapter-5-Expedited-Licensure-Amended-November-14-2023-FINAL.pdf, (last visited January 22, 2024).

through the compact. Each member state has two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory boards, such as Florida, the member appoints one representative from each member board. A Commissioner must be:

- An allopathic or osteopathic physician appointed to a member board.
- An executive director, executive secretary, or similar executive or a member board, or
- A member of the public appointed to a member board.

The compact requires the Commission to establish an executive committee, which shall have the power to act on behalf of the Commission. All Commission and executive committee meetings must be open to the public and public notice must be provided. However, a meeting may be closed to the public, in full or in portion, when it is determined by a two-thirds vote of the Commissioners present, that an issue or matter to be discussed is confidential or privileged as designated in the compact. The Commission must make its information and official records, to the extent, not otherwise designated in the compact or by its rules, available to the public for inspection.

Coordinated Information System

The compact requires the Commission to establish a database of all physicians licensed, or who have applied for licensure under the compact. Member boards are required to report any public action or complaints against a licensed physician who has applied or received an expedited license through the compact and any disciplinary or investigatory information as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission.

Each member board must report the name, National Provider Identifier (NPI) number, and all necessary and proper disciplinary or investigatory information of a public complaint or action on a form provided by the Commission within 10 business days after a public complaint or action has been entered.[84] Member boards must submit updated reports to the Commission upon changes to the status of any reported action.

All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters. Upon request, member boards may share complaint or disciplinary information about physicians to another member board.

Effect of the bill - Interstate Medical Licensure Compact

The bill requires Florida to join the Interstate Medical Licensure Compact by adopting the entirety of the compact terms into state law. Florida physicians will be able to obtain an expedited licensure in compact member states. Likewise, eligible physicians in compact member states will be able to obtain expedited licensure in Florida.

The bill also requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

Physical Therapy Licensure Compact

Physical Therapy Licensure in Florida

The Physical Therapy Practice Act is codified in chapter 486, F.S. Licensed physical therapist are regulated by the Board of Physical Therapy Practice (Board) within in DOH.[85] A physical therapist must

[84] Rule 6.3 of the IMLCC Rules, available at https://imlcc.org/wp-content/uploads/2018/12/IMLCC-Rule-Chapter-6-Coordinated-Information-System-Joint-Investigations-and-Disciplinary-Actions-Adopted-November-16-2018.pdf (last visited January 22, 2024). "Necessary and proper disciplinary and investigatory information" includes type of action, date action was taken, whether the action results in removal of the physician's Compact license, whether the action is to initiate a joint investigation, name of Board or entity that took action, and current status and changes in status of any action.
[85] Section 486.023, F.S.

practice physical therapy in accordance with the provisions of the practice act and Board rules.[86] The practice of physical therapy includes:[87]

- The performance of physical therapy assessments;
- The treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other health condition, and the rehabilitation of such disability, injury, disease, or other health condition by alleviating impairments, functional movement limitations, and disabilities by designing, implementing, and modifying treatment interventions through use of:
    - Therapeutic exercise;
    - Functional movement training in self-management and in-home, community, or work integration or reintegration;
    - Manual therapy;
    - Massage;
    - Airway clearance techniques;
    - Maintaining and restoring the integumentary system and wound care;
    - Physical agent or modality;
    - Mechanical or electrotherapeutic modality;
    - Patient-related instruction;
    - The use of apparatus and equipment in the application of the above;
- The performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or
- The performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

To be eligible for licensure as a physical therapist (PT), an applicant must:[88]

Be 18 years of age;
Be of good moral character; and
Satisfy the following educational requirements:

- Have graduated from a school of physical therapy which has been approved for the educational preparation of physical therapists by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation or the U.S. Department of Education at the time of her or his graduation and have passed, to the satisfaction of the Board, the American Registry Examination prior to 1971 or a national examination approved by the Board to determine her or his fitness for practice as a physical therapist;
- Have received a diploma from a program in physical therapy in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapists in this country, as recognized by the appropriate agency as identified by the Board, and have passed to the satisfaction of the Board an examination to determine her or his fitness for practice as a physical therapist;[89] or
- Be entitled to licensure without examination.

Physical Therapist Assistant Licensure

A physical therapist assistant (PTA) is an individual who performs patient-related activities, including the use of physical agents, under the direction of a physical therapist.[90] To be licensed as a PTA an applicant must:[91]

- Be at least 18 years old;
- Be of good moral character; and

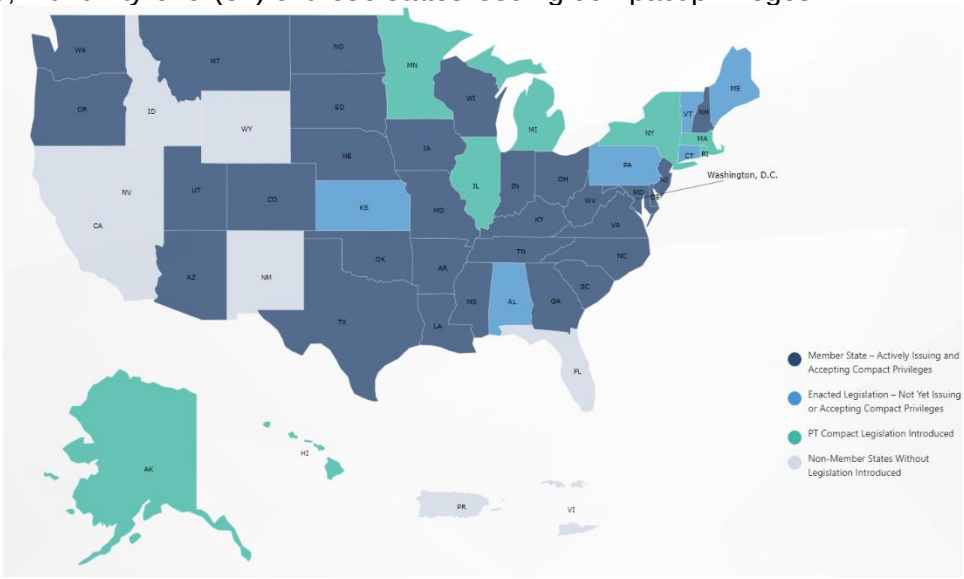
[86] Sections 486.031 and 486.102, F.S.
[87] Section 486.021(11), F.S.
[88] Section 486.031, F.S.
[89] Section 486.081, F.S.
[90] Section 486.021(6), F.S.
[91] Section 486.102, F.S.

- Have graduated from a school that provides at least a two-year course of study for the preparation of physical therapist assistants and is recognized by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation or the U.S. Department of Education at the time of graduation and have passed a board-approved examination to determine his or her fitness to practice; or
- Have graduated from a school that provides a course for physical therapist assistants in a foreign country that has educational credentials that have been deemed equivalent to the requirements in this country, as recognized by the agency, as identified by the board, and have passed a board-approved examination to determine his or her fitness to practice;
- Be entitled to licensure without examination as provided in section 486.107, F.S., or
- Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in this state which was accredited at the time of enrollment; and have graduated or is eligible to graduate from such school by July 1, 2018, and have passed a board-approved examination to determine his or her fitness to practice.

The board may issue a PTA license to an applicant who presents evidence to the board, under oath, of licensure in another state, the District of Columbia, or a territory, if the board determines that standards for registering or licensing of a physical therapist assistant in such other state are as high as the standards of this state.[92]

Physical Therapy Licensure Compact

The Physical Therapy Licensure Compact (PT Compact or compact) is a mutual recognition licensure compact that allows a physical therapist who holds a license in their home state to apply for a "compact privilege" to practice in another state. Compact privilege also authorizes a physical therapist licensed by a home state to practice telehealth in member states. Currently, there are thirty-seven (37) compact member states, with thirty-one (31) of those states issuing compact privileges.[93]



To exercise compact privilege under the PT Compact, PTs and PTAs must meet all of the following requirements:

- Hold a license in the home state;
- Have no encumbrance on any state license;
- Be eligible for compact privilege in all member states;
- Have no adverse actions taken against the license or compact privilege within the preceding two (2) years;
- Notify the Physical Therapy Compact Commission that the licensee is seeking compact privilege within a remote state;

[92] Section 486.107, F.S.
[93] PT Compact, *Compact Map*, available at https://ptcompact.org/ptc-states, (last visited January 22, 2024).

- Pay any applicable fees, including any state fee, for the compact privilege;
- Meet any jurisprudence requirement established by the remote state in which the licensee is seeking compact privilege; and
- Report any adverse action taken by any nonmember state to the Physical Therapy Compact Commission within 30 days after the action is taken.

To maintain compact privilege, the licensee must continue to meet all of the requirements above in the remote state. A licensee providing physical therapy in a remote state must also comply with the laws and rules of that state and are subject to that state's regulatory authority.

Compact privilege is valid until the expiration date for the home license and is renewable upon renewal of the home state license. If the home state license is encumbered, the licensee shall lose compact privilege to practice in all remote states until the home state license is no longer encumbered and two (2) years have passed since the adverse action.

State Participation in the Physical Therapy Licensure Compact

Under the PT Compact, a member state must grant compact privilege to a licensee holding a valid unencumbered license in another member state. To participate in PT Compact, states must meet all of the following requirements:

- Participate fully in the Physical Therapy Compact Commission (Commission) data system, including using the Commission's unique identifier;
- Have a mechanism in place for receiving and investigating complaints about licensees;[94]
- Notify the commission of any adverse action or the availability of investigative information regarding a licensee;
- Require a criminal background check, including the submission of fingerprints or other biometric-based information, as condition of licensure;
- Comply with Commission rules;
- Require the licensee to pass a recognized national examination as a requirement for licensure;
- Have continuing competence requirements as a condition for license renewal;

Physical Therapy Compact Commission

The PT Compact establishes the Physical Therapy Compact Commission as the governing body and the entity responsible for creating and enforcing the rules and regulations of the compact. Each member state may delegate one member, selected by that member state's physical therapy licensing board, to serve on the Commission. The compact requires the Commission to establish and elect an executive board to act on behalf of, and within the powers granted to them by, the Commission.

All Commission meetings must be open to the public and public notice must be given. However, the Commission or the executive committee or other committees of the Commission may convene in a closed non-public meeting if confidential or privileged information must be discussed. Nothing in the compact shall be construed to be a waiver of sovereign immunity.

Shared Data System

The PT Compact requires the Commission to develop and maintain a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states. Compact member states must submit certain licensure information to the data system on all PTs and PTAs to whom the compact applies, including identifying information, licensure data, and any adverse actions taken against the PT or PTA's license or compact privilege. Investigative information pertaining to a licensee in any member state must be available to other member states. A member state may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.

[94] Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations, including physical therapist and physical therapist assistants under the Division of Medical Quality Assurance in DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 486.125, F.S., identifies acts that constitute grounds for w hich disciplinary actions may be taken against a physical therapist or a physical therapist.

Effect of the bill - Physical Therapy Licensure Compact

The bill requires Florida to join the Physical Therapy Licensure Compact. The bill authorizes eligible licensed Florida PTs and PTAs to obtain a compact privilege to provide services to out-of-state patients in person or through telehealth in compact member states. It also allows out-of-state licensed PTs and PTAs in member states with a Florida compact privilege to provide services to Floridians via telehealth and in-person.

The bill amends current law to allow compact implementation. The bill also requires the Board of Physical Therapy Practice to submit certain specified information on all licensed PTs and PTAs under the compact to a shared data system, including, identifying information, licensure data, and any adverse actions taken against the PT or PTA's license. It requires PTs and PTAs to withdraw from all practice under the compact if the PT or PTA is in an impaired practitioner program. The bill also exempts out-of-state licensed PTs and PTAs who practice under the compact from licensure requirements in this state. The bill authorizes the Board to take adverse action against a licensed PT or PTA's compact privilege and impose disciplinary actions for violation of prohibited acts.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill preserves the regulatory authority of the state's current system of state licensure.

Licensure of Physicians of Foreign-Trained Physicians

Chapter 458, F.S., provides for the licensure and regulation of the practice of allopathic medicine by the Florida Board of Medicine within the DOH. The chapter imposes requirements for licensure examination and licensure by endorsement.[95]

Licensure by Examination

An individual seeking to be licensed by examination as a physician must meet the following requirements:[96]

- Be at least 21 years of age;
- Be of good moral character;
- Not have committed an act or offense that would constitute the basis for disciplining a physician under s. 458.331, F.S.;
- Completed two years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry prior to entering medical school;
- Graduated from 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;
- Completed at least one year of approved residency training; and
- Obtained a passing score on:
    - The United States Medical Licensing Examination (USMLE);
    - 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.

[95] An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida in lieu of examination. 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. S. 458.313(1)(c), F.S.

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

Licensure by Examination – Foreign-Trained Applicant

Foreign-trained applicants must meet the same requirements as U.S.-trained applicants related to age, character, background checks, prior disciplinary action, completion of post-secondary education and obtaining a passing score on the USMLE, FLEX or SPEX, as applicable. Applicants who graduated from 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, are required to have completed at least one year of an approved residency training.[97] Applicants who graduated from an allopathic foreign medical school that has not been certified pursuant to statute must have:

- An active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG);
- Passed the ECFMG's examination; and
- Completed an approved residency or fellowship of at least 2 years in one specialty area.

Residency Programs

A residency, also called graduate medical education, is a training program that medical students and international medical school graduates must complete at a postgraduate hospital. The duration of the program varies in length from three to eight years depending on the specialty.[98] While in a residency program, residents train in a specialty or core program (e.g., general surgery, pediatrics, or internal medicine). The residency placement occurs during the final year of medical school. Residents are matched to a program based on certain criteria including resident preference for a particular specialty, aptitude based on medical school grades and performance in rotations, and available residency positions or slots.[99]

In Florida an approved one-year residency consists of a course of study and training in a single program for a period of at least 12 months by a medical school graduate (resident).[100] The hospital and the program in which the resident is participating must be accredited for the training and teaching of physicians by the Accreditation Council for Graduate Medical Education (ACGME), College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC) and the resident must be assigned an allocated position or slot[101] approved by the ACGME, CFPC or RCPSC.[102]

Similarly, an approved two-year residency in one specialty area consists of two progressive years in a course of study and training as long as each year is accepted by the American Board of Medical Specialties in that specialty for at least twenty-four months by a medical school graduate. The hospital and the program in which the resident is participating must meet the same accreditation and slot assignment requirements as an approved one-year residency.[103]

As noted above, foreign-trained applicants are required to complete a 1-year or 2-year approved residency to become licensed in Florida. The Florida Board of Medicine (BOM) limits the approved residencies to those accredited by the ACGME, CFPC and the RCPSC. These entities only accredit U.S. and Canadian medical residencies. Thus, a foreign-trained physician who did not complete a U.S. or Canadian residency is required to complete an additional residency irrespective of how long they may have practiced medicine and whether they previously completed a residency in another country.

Certification of Foreign Educational Institutions

[97] *Id.*
[98] USMLE Courses, *Residency & Match,* at https://www.usmle-courses.eu/residency-match/ (last visited January 22, 2024).
[99] OPPGA, *Florida's Graduate Medical Education System,* Report No. 14.08, February 2014 at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/_physician-workforce-development-and-recruitment/additional-council-resources/OPPAGAGMERepor14-08February2014.pdf (last visited January 22, 2024).
[100] 64B8-4.004 F.A.C.
[101] A residency position or slot refers to federally supported residency training slots. These slots are typically funded through Medicare Graduate Medical Education Payments, which cover Medicare's share of the costs of a hospital's approved medical residency program. These costs include direct costs of operating a residency program, such as resident stipends, supervisory physician salaries, and administrative costs. In fiscal year 2020, Medicare paid $16.2 billion for medical residency training. See Congressional Research Service, *Medicare Graduate Medical Education Payments: An Overview.,* September 29, 2022 at https://crsreports.congress.gov/product/pdf/IF/IF10960, (last visited January 22, 2024).
[102] Rule 64B8-4.004, F.A.C.
[103] *Id.*

Section 458.314, F.S., allows for the evaluation and certification of foreign medical schools that provide an education that is reasonably comparable to that of similar accredited institutions in the U.S. and which adequately prepares its students for the practice of medicine. Foreign medical schools are certified by DOH. To be considered for certification a foreign medical school must submit an application to DOH and complete the certification process outlined in Rule 64B8-14.003, F.A.C.

Effect of the bill - Licensure of Physicians of Foreign-Trained Physicians

The bill removes the current law requirement for foreign-trained physicians to complete an approved residency program in the U.S. to obtain a license to practice medicine in Florida and creates an alternative licensing requirement for graduates of a foreign medical school. Specifically, the bill allows a graduate of a foreign-trained medical school to forgo completion of an approved residency if the applicant meets all meets all of the following criteria:

- Holds an active, unencumbered license to practice medicine in a foreign country;
- Has actively practiced medicine in the four years preceding the date in which the foreign graduate submitted an application to obtain licensure;
- Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction; or
- Has an offer for full-time employment as a physician from a health care provider that operates in Florida, and maintains employment with the employer, or another health care provider in Florida, for two consecutive years after licensure. The physician must notify the board within five days after any change of employer.

The foreign-trained applicant must still meet all other statutory requirements for licensure, including having graduated from a foreign medical school that provides an educational program reasonably comparable to that of similarly accredited institutions in the U.S.

For foreign medical schools that do not complete the certification process, the bill authorizes the Board of Medicine to exclude the foreign medical school from being considered an institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S.

Temporary Certificates for Practice in Areas of Critical Need

Areas of Critical Need

The Surgeon General is responsible for determining areas of critical need in the state.[104] The determination by the Surgeon General defines the areas of the state wherein a physician may be issued a temporary certificate to practice in areas of critical need. The determination also includes a provision which allows physicians with an active temporary certificate for practice in an area of critical need to continue to practice under the certificate until it is due for renewal, regardless if the location where the physician practices loses its HPSA designation.[105] In August 2022, the Surgeon General determined that all mental health and primary care Health Professional Shortage Areas (HPSA),[106] Volunteer Health Care Provider participants,[107] and free clinics are areas of critical need.[108]

Temporary Certificates for Practice in Areas of Critical Need

A temporary certificate allows a qualified physician to provide services in certain settings in areas of critical need without undergoing the process of obtaining full licensure to practice in Florida.

[104] Sections. 458.315(3)(a) and 459.0076(3)(a), F.S.
[105] *Supra*, note **Error! Bookmark not defined.**.
[106] HRSA, *What is Shortage Designation?* (2023). Available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas (last visited January 22, 2024).
[107] S. 766.1115, F.S. *See also*, Florida Department of Health, *The Volunteer Healthcare Provider Program Online Listing of Participating Providers*. Available at https://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-provider-listing/index.html (last visited January 22, 2024).
[108] Florida Department of Health, Determination of Areas of Critical Need Pursuant to Sections 458.315 and 459.0076, Florida Statutes (2022). Available at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/DeterminationofAreasofCriticalNeed-8-10-22.pdf (last visited January 22, 2024).

The Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) may issue a temporary certificate to practice in an area of critical need to a physician[109] with an active license to practice in any United States jurisdiction[110] who will:[111]

- Practice in an area of critical need;
- Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

The BOM and the BOOM are authorized to administer an abbreviated oral examination to determine a physician's competency. A written examination is not required.[112] The boards must review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification within 60 days after the receipt of the application.[113] The boards may not issue a temporary certificate to a physician who is under investigation in any jurisdiction in the US for an act which would constitute a violation of the relevant practice act.[114]

A temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[115] However, the boards must review the temporary certificate holder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[116] A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.[117]

There are currently 934 physicians with active temporary certificates to practice in areas of critical need.[118] The BOM and the BOOM are not authorized under current law to issue temporary certificate for practice in areas of critical need to physician assistants.[119] Likewise, the Board of Nursing (BON) is not authorized to issue temporary certificates to practice in areas of critical need to advanced practice registered nurses (APRNs).

Physician Assistants and APRNs

Physicians assistants (PA) and APRNs are non-physician advanced practice providers, sometimes considered "physician extenders."[120] PAs and APRNs are able to complement the physician workforce in a manner that expands the capacity of a health care system while ensuring safe and efficient patient care.[121] The role of PAs and APRNs is especially important in areas experiencing a shortage of health care providers.

PA is a health care practitioner who practices under the direct or indirect supervision of an allopathic or osteopathic physician. PAs may provide a number of medical services including:[122]

[109] Allopathic physicians are licensed and regulated by the Board of Medicine (BOM), pursuant to Ch. 458, F.S. Osteopathic physicians are licensed and regulated by the Board of Osteopathic Medicine (BOOM), pursuant to Ch. 459, F.S.
[110] Sections 458.315 and 459.0076, F.S.
[111] Sections 458.315(2) and 459.0076(2), F.S.
[112] Sections 458.315(3)(d) and 459.0076(3)(d), F.S.
[113] *Id.*
[114] Sections 458.315(2) and 459.0076(2), F.S.
[115] Sections 458.315(3) and 459.0076(3), F.S.
[116] *Id.*
[117] *Id.*
[118] Correspondence from the Department of Health to Health and Human Services Committee staff dated December 14, 2023. On file with the Health and Human Services Committee.
[119] In Florida, PAs are governed by the respective physician practice act governing the physician under which they practice. As such, PAs are governed by either ch. 458, F.S., if they practice under an allopathic physician, or by ch. 459, F.S., if they practice under an osteopathic physician.
[120] Milewski, M.D., Coene, R.P., Flynn, J.M., Imrie, M.N., Annabell, L., Shore, B.J., Dekis, J.C., Sink, E.L. (2022). *Better Patient Care Through Physician Extenders and Advanced Practice Providers*. Journal of Pediatric Orthopaedics 42, 18-S24. DOI: 10.1097/BPO.0000000000002125
[121] Johal, J., & Dodd, A. (2017). Physician extenders on surgical services: a systematic review. Canadian journal of surgery. Journal canadien de chirurgie, 60(3), 172–178. https://doi.org/10.1503/cjs.001516
[122] Florida Academy of Physician Assistants, *What is a PA*? Available at https://www.fapaonline.org/page/whatisapa (last visited January 22, 2024).

- Physical examinations;
- Diagnosis and treatment of illness;
- Counsel on preventative health care;
- Assistance in surgery; and
- Prescribing of medication.

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[123] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[124] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than ten PAs at any time.[125]

An APRN is a licensed professional nurse who is additionally licensed in an advanced nursing practice, including certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses.[126] In addition to the practice of professional nursing,[127] APRNs perform advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[128] APRNs are also authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[129]

Effect of the bill - Temporary Certificates for Practice in Areas of Critical Need

The bill authorizes the BOM and BOOM to issue temporary certificates to practice in areas of critical need to physician assistants under the same specified criteria as required for physicians to practice in those areas under a temporary certificate.

The bill authorizes the BON to issue temporary certificates to practice in areas of critical need to APRNs who hold a valid license in any U.S. jurisdiction and meets the educational and training requirements established by the BON. To be eligible for a temporary certificate an APRN must practice in one of the following settings:

- An area of critical need;
- A county health department; correctional facility;
- A Department of Veterans' Affairs clinic;
- A community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state.

The bill requires the BON to review an application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification within 60 days after the receipt of the application. The BON may administer an abbreviated oral examination to determine an applicant's competency, but may not require a regular, written examination.

The bill prohibits the BON from issuing a temporary certificate to practice in an area of critical need to any APRN who is under investigation in any jurisdiction in the U.S. for an act that would constitute a violation of ch. 464, F.S., until the investigation is complete, at which time disciplinary action may be taken under s. 464.018, F.S.

[123] Sections 458.347(2)(f), F.S., and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[124] Rules 64B8-30.012, F.A.C., and 64B15-6.010, F.A.C.
[125] Sections 458.347(15), F.S., and 459.022(15), F.S.
[126] Section 464.003(3), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from "Advanced Registered Nurse Practitioner (APRN)" to "Advanced Practice Registered Nurse (APRN)," and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (*see* ch. 2018-106, Laws of Fla.).
[127] "Practice of professional nursing" means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences. *See* s. 464.003(19), F.S.
[128] Section 464.012(3)-(4), F.S.
[129] Section 464.003, F.S., and s. 464.012, F.S.

The bill requires the BON to review each temporary certificate holder at least annually to ascertain that the certificate holder is complying with the minimum requirements of the Nurse Practice Act and its adopted rules. If the BON determines that the certificate holder is not meeting the requirements, the BON must revoke the temporary certificate or impose restrictions or conditions as a condition of continued practice.

An APRN must notify the BON of all approved institutions in which the APRN practices within 30 days of accepting employment. A certificate holder may work for any approved entity in an area of critical need or as authorized by the State Surgeon General.

Graduate Assistant Physician Licensure

Limited Licenses

Both the BOM and the BOOM are authorized to issue limited licenses. Licensed allopathic physicians are issued limited licenses to practice in areas of critical need, and licensed osteopathic physicians are issued limited licenses to practice in areas of critical need or medically underserved areas, though the process and authorizations for each are slightly different.[130]

An allopathic physician wishing to obtain a limited license to practice in the employ of a public or private 501(c)(3) non-profit[131] agency or institution located in a BOM determined area of critical medical need, must submit an application and fee, unless the applicant includes an employer's statement that the position is uncompensated, in which case all fees are waives, and demonstrates that the applicant:

- Has been licensed to practice medicine in any U.S. jurisdiction for at least 10 years;
- Intends to practice only in areas of critical need; and
- If not fully retired at the time of application, will only practice on an uncompensated basis.

If it has been more than three years since the limited license applicant has been in active practice, the full-time director of the county health department, or a BOM approved licensed physician, must supervise the applicant for six months after licensure, unless the BOM determines that a shorter period will be sufficient. Procedures for such supervision shall be established by the BOM.

The BOOM is also authorized to issue limited licenses to certain osteopathic physicians who will only practice in areas of critical need or in medically underserved areas. A limited license may be issued to an osteopathic physician who:[132]

- Submits the licensure application and required fee;
- Provides proof that he or she has been licensed to practice osteopathic medicine in any U.S. jurisdiction in good standing for 10 years;
- Has completed 40 hours of CME within the preceding two-year period; and
- Will practice only in the employ of public agencies, nonprofit entities, or agencies or institutions in areas of critical need or in medically underserved areas.

If it has been more than three years since the osteopathic limited license applicant has actively practiced medicine, the full-time director of the local county health department must supervise the applicant for at least six months after the issuance of the limited license unless the BOOM determines a shorter period will be sufficient.[133]

The BOOM must review the practice of each osteopathic 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.[134]

[130] Sections 458.317 and 459.0075, F.S.
[131] Section 501(c)(3) of the Internal Revenue Code.
[132] Section 459.0075, F.S., and Fla. Admin. Code R. 64B15-12.005 (2023).
[133] Section 459.0075(2), F.S.
[134] Section 459.0075(5), F.S.

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[135] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[136]

The National Residency Matching Program (NRMP) matches allopathic and osteopathic medical school graduates to GME programs. The GME application process is competitive and graduates typically apply for more than one residency.[137] In 2023, the residency match had a 99% position fill rate.[138] Despite this success rate there are still a significant number of graduates that fail to match. For example, in 2023, there were 3,000 medical school graduates nationwide that failed to match with a GME program.[139] These graduates are unable to provide care to patients until they are matched with a GME program which may take multiple application cycles.

Currently, neither the BOM nor the BOOM are authorized to issue limited licenses to allopathic and osteopathic school graduates who fail to match with a GME program.

Effect of the bill - Graduate Assistant Physician Licensure

The bill authorizes the BOM and BOOM to issue a graduate assistant physician (GAP) license to a graduate of an allopathic or osteopathic medical school who has not matched with a GME program. The BOM and the BOOM, respectively, must issue a GAP license for a duration of two years to an applicant who meet all of the following:

- Is a graduate of an allopathic or osteopathic medical school or college, as applicable, approved by an accrediting agency recognized by the U.S. Department of Education;
- Has successfully passed all parts of the USMLE for allopathic physicians or the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the BOOM;
- Has not received a residency match from the NRMP within the first year following graduation from medical school;
- Is at least 21 years of age;
- Is of good moral character;
- Has submitted documentation that the applicant has agreed to enter into a written protocol, with specific provisions required by applicable boards rules, drafted by a Florida physician with a full, active, and unencumbered license upon the issuance of the limited license;
- Has submitted a copy of the protocol to the appropriate board;
- Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331 or 459.015, F.S., as applicable; and
- Has submitted to the DOH a set of fingerprints.

The bill prohibits the DOH from issuing a limited license, or the BOM or the BOOM from certifying any applicant for a limited licensure, who is under investigation in another jurisdiction for an offense which

[135] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited January 22, 2024).
[136] *Id.*
[137] *Graduate Medical Education in Florida*, Office of Program Analysis and Government Accountability, December 2023, available at https://oppaga.fl.gov/Products/ReportDetail?rn=23-GME (Last visited January 22, 2024).
[138] *Id.*
[139] *Medical Students Show Leadership in Call for More GME Slots*, American Medical Association, April 17, 2023 (available at https://www.ama-assn.org/education/gme-funding/medical-students-show-leadership-call-more-gme-slots, Last visited January 22, 2024).

would constitute a violation of ch. 456, F.S., orch. 458 and 459, F.S., as applicable; and the applicant is subject to disciplinary action under ss. 458.331 and 459.015. F.S., as appropriate. If a board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under ss. 458.331 or 459.015, F.S, as applicable, the board may enter an order imposing one of the following terms:

- Refusal to certify to the DOH an application for a GAP limited license; or
- Certification to the DOH of an application for a GAP limited license with restrictions on the scope of practice of the licensee.

The bill authorizes a one-time renewal for one additional year of the limited license provided licensee submits to the appropriate board documentation of:

- Actual practice under the required protocol during the initial limited licensure period; and
- Applications he or she has submitted for accredited graduate medical education training programs.

The bill authorizes GAP licensee to only provide health care services under the direct supervision of the board approved Florida physician, with a full, active, and unencumbered license. The supervising physician:

- May supervise no more than two GAP licensees;
- Must be physical presence at the location where the services are rendered; and
- Must draft the protocol to specify the duties and responsibilities of the limited licensed GAP as specified by board rule.

The bill requires the supervising physician to be liable for any acts or omissions of the GAP licensee acting under the physician's supervision and control; and authorizes third-party payors to reimburse employers of a GAP licensee for covered services.

The bill authorizes the BOM and the BOOM to adopt rules to implement these sections.

Medical Faculty Certificates

The BOM may issue medical faculty certificates. Medical faculty certificates allow physicians to practice medicine in Florida without the prerequisite of sitting for and successfully passing a national examination. While they have the same rights and responsibilities as other licensed physicians,[140] physicians issued medical faculty certificates may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals.[141]

A physician is eligible to receive a medical faculty certificate without examination if they fulfill all of the following prerequisites:[142]

- A graduate of an accredited medical school or its equivalent, or a graduate of a foreign medical school listed with the World Health Organization.
- Hold a valid, current license to practice medicine in another jurisdiction.
- Complete an application form and remit a nonrefundable application fee not to exceed $500.[143]
- Complete an approved residency or fellowship of at least one year or equivalent training.
- Are at least 21 years of age.
- Are of good moral character.

[140] Section 458.3145(3), F.S.
[141] Section 458.3145(2), F.S.
[142] Section 458.3145(1), F.S.
[143] BOM's nonrefundable application fee for medical faculty certificates is $350. If the application is for an initial license, an initial license fee adds another $355 to the total. In addition, BOM charges a Neurological Injury Compensation Association (NICA) Fund fee between $0 and $5,000 depending on practitioner status. For medical faculty certificate applicants who seek authorization to dispense pharmaceuticals, there is a $100 dispensing practitioner fee. Board of Medicine, *Application for Medical Faculty Certificate for Allopathic Physicians*, p. 4 (revised Dec. 2020) https://flboardofmedicine.gov/apps/app-medical-faculty-certificate.pdf (last visited Dec. 13, 2023).

- Have not committed any act in Florida or any other jurisdiction which would constitute the basis for disciplining a physician.
- Complete, before medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by BOM.[144]
- Accept a full-time faculty appointment to teach in a program of medicine at one of the following schools:
    - The University of Florida.
    - The University of Miami.
    - The University of South Florida.
    - The Florida State University.
    - The Florida International University.
    - The University of Central Florida.
    - The Mayo Clinic College of Medicine and Science (Jacksonville).
    - The Florida Atlantic University.
    - The Johns Hopkins All Children's Hospital (St. Petersburg).
    - Nova Southeastern University.
    - Lake Erie College of Osteopathic Medicine.

Medical faculty certificates automatically expire when the physician's relationship with the medical school terminates or after a period of 24 months.[145] Medical faculty certificates are renewable every 2 years, but the physician must apply for the renewal and provide certification by the dean of the medical school that the physician is a distinguished medical scholar and an outstanding practicing physician.[146] An annual review of each medical faculty certificate recipient is made by the dean of the certificate recipient's accredited 4-year medical school and reported to BOM.[147]

In any year, the maximum number of extended medical faculty certificate holders may not exceed 30 persons at each medical school.[148] The exception is The Mayo Clinic College of Medicine and Science in Jacksonville where the maximum number of extended medical faculty certificate holders may not exceed 10 persons.[149]

As of August 17, 2023, BOM oversees 58 active number of certificate holders at the following institutions:[150]

Medical School of Teaching Institution	Medical Faculty Certificate Holders
H. Lee Moffitt Cancer Center and Research Institute (USF)[151]	0
Florida Atlantic University	0
Florida International University	2
Florida State University	1
Lake Erie College of Osteopathic Medicine	0
Nova Southeastern University	1
The Johns Hopkins All Children's Hospital (St. Petersburg)	0
The Mayo Clinic College of Medicine and Science (Jacksonville)	2
University of Central Florida	0
University of Florida	32
University of Miami	18
University of South Florida	2

[144] This education requirement is only applicable to applicants who graduated medical school after October 1, 1992. s. 458.3145(1)(h), F.S.
[145] Section 458.3145(2), F.S.
[146] *Id*.
[147] Section 458.3145(5), F.S.
[148] Section 458.3145(4), F.S.
[149] *Id*.
[150] Correspondence from Department of Health to Health and Human Services Committee dated December 14, 2023 (on file with the Health and Human Services Committee). Data reflects the number of medical certificate holders employed full-time on August 17, 2023. Thus, this number for any day of the year could be different than the number (70) published in MQA's Annual Report and Long-Range Plan FY 22-23.
[151] Sections 458.1345(4), 1004.43, F.S.

For FY 22-23, a total of 29 initial medical faculty certificates were issued out of 45 initial applications received.[152] Out of the total 45,352 complaints and 5,246 investigations that MQA's Bureau of Enforcement handled during FY 22-23, none involved medical faculty certificates.[153]

Effect of the bill - Medical Faculty Certificates

The bill eliminates the cap on the maximum number of medical faculty certificates that the BOM may issue to eligible physicians.

Restricted Licenses For Certain Experienced Foreign-Trained Physicians

Section 458.3124, F.S., was created in 1997 as path to a restricted license, and ultimately a full Florida license, by permitting foreign trained physicians with five years of experience, who had been residents of Florida since 1986, to apply to the DOH by December 31, 2000, to take the USMLE, Part III. Once the USMLE, Part III, was passed, the restricted licensee practiced under the supervision of a BOM approved licensee with the first year being direct supervision and the second year being indirect supervision in a community service setting.

Effect of the bill - Restricted Licenses For Certain Experienced Foreign-Trained Physicians

The bill repeals the obsolete s. 458.3124, F.S., since that section's applicability to the issuance of restricted medical licenses ended December 31, 2000.

Autonomous APRN Practice

Current law authorizes an APRN who meets certain eligibility criteria to engage in autonomous practice only in primary care, which includes family practices, general pediatrics and general internal medicine, as defined by BON rule and midwifery, without a supervising physician or written protocol with a physician.[154] The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions."[155]

To engage in autonomous practice, an APRN must hold active and unencumbered Florida or multi-state license and have:

- Completed at least 3,000 clinical practice hours or clinical instructional hours[156] supervised by a physician with an active license within the five-year period immediately preceding the registration request;
- Not have been subject to any disciplinary action during the five years immediately preceding the application;
- Completed three graduate-level semester hours, *or the equivalent*, in pharmacology and three graduate-level semester hours, *or the equivalent,* in differential diagnosis within the five-year period preceding the registration request;[157] and
- Any other registration requirements provided by BON rule.

An autonomous APRN registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN and RN. To maintain autonomous APRN registration, an

[152] *See footnote 150*.
[153] *Id*.
[154] Section 464.0123(3)(a)1., F.S.
[155] Fla. Admin. Code R. 64B9-4.001(12), (2023).
[156] The bill defines "clinical instruction" as education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in a clinical nursing specialty area.
[157] *See* Fla. Admin. Code R. 64B9-4.020(3),(2023) where the BON defined, by rule, *the equivalent of* three graduate-level semester hours in pharmacology and *the equivalent of* three graduate-level semester hours in differential diagnosis as equal to forty-five (45) Continuing Education credits offered in those areas by the entities set forth in Section 464.013(3)(b), F.S. and Fla. Admin. Code R. 64B9-4.002(2), (2023).

autonomous APRN must complete at least 10 hours of BON approved CE for each biennial renewal in addition to the 30 hours of CE required for renewal of the APRN license.[158]

Autonomous Practice by Certified Nurse Midwives (CNM)

CNMs is an APRN who has a specialty certification in midwifery. A CNM provides care during pregnancy, childbirth, and the postpartum period, as well as sexual and reproductive health care, gynecologic health care, and family planning services.[159]

A CNM may perform the following procedures to the extent authorized by the established protocol approved by the health care facility in which they are operating, or by the supervising physician if performing a delivery in a patient's home:[160]

- Perform superficial minor surgical procedures.
- Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.
- Order, initiate, and perform appropriate anesthetic procedures.
- Perform postpartum examination.
- Order appropriate medications.
- Provide family-planning services and well-woman care.
- Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.

A CNM who is registered to practice autonomously may only perform midwifery services[161] if they have a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician.[162] CNMs have encountered difficulty obtain written referral agreements from physicians. Currently, only 83 of the 1,202 licensed CNMs in Florida are registered for autonomous practice.[163]

Effect of the bill - Autonomous Practice by Certified Nurse Midwives (CNM)

The bill revises the requirements under which an autonomous CNM may provide out-of-hospital intrapartum care. The bill outlines specific safety procedures that must be in place before an autonomous CNM may provide out-of-hospital intrapartum care, and eliminates the existing requirement that an autonomous CNM have a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician to do so.

As a condition precedent to providing out-of-hospital intrapartum care, a CNM engaged in autonomous practice must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The written policy must include an emergency plan-of-care form to be signed by the patient before admission. The plan-of-care form must contain:

- The name and address of the closest hospital that provides maternity and newborn services;
- Reasons for which transfer of care would be necessary, including the transfer-of-care conditions prescribed by BON rule; and
- Ambulances or other emergency medical services that would be used to transport the patient in the event of an emergency.

When an emergency transfer of care is required, the bill requires an autonomous CNM provide the receiving provider with the patient's emergency plan-of-care form, and the patient's prenatal records

[158] Current law provides an exception to the 10 hours of CE in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.
[159] American College of Nurse-Midwives, *Definition of Midwife and Scope of Practice of Certified Nurse-Midwives and Certified Midwives*. Available at https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007476/Definition%20Midwifery%20Scope%20of%20Practice_2021.pdf (last visited January 22, 2024).
[160] S. 464.012(4)d), F.S.
[161] *See* s. 464.012(4)(c), F.S.
[162] S. 464.0123(3)(b), F.S.

including patient history, prenatal laboratory results, sonograms, prenatal care flow sheets, maternal fetal medical reports, and labor flow charting and current notations; and it requires an autonomous CNM to provide the receiving provider with a verbal summary of the information on the patient's emergency plan-of-care form, and make himself or herself immediately available for consultation.

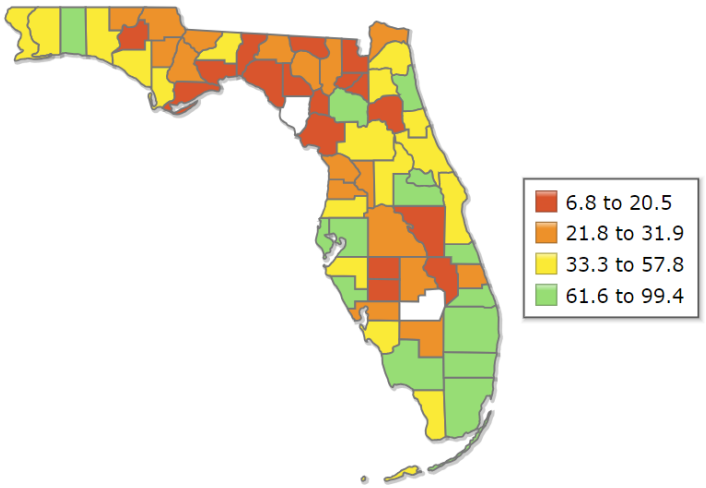
The bill authorizes the BON to adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the licensure CNMs engaged in autonomous practice.

Dental Student Loan Repayment Program

Access to Dental Care and Dental Workforce in Florida

There are 7,651 dental HSPAs in the U.S., 266 of which are in Florida.[164] In 2022, there were approximately 59 licensed dentists per 100,000 people in Florida; however, this ratio varies greatly across the state. Most dentists are disproportionately concentrated in the more populous areas of the state. Two counties, Dixie and Glades, do not have any licensed dentists.[165]

Licensed Dentists per 100,000 Floridians FY 2021-2022[166]



There is a noticeable shortage of dentists in certain parts of the state, especially the central Panhandle counties and interior counties of south Florida.[167] Lower patient densities, rural income disparities, and lower dental care reimbursement levels make it difficult to recruit and retain dentists in rural communities of the state.[168] Lack of access to dental care can lead to poor oral health and poor overall health.[169] Research has shown a link between poor oral health and diabetes, heart and lung disease, stroke, respiratory illnesses, and adverse birth outcomes including the delivery of pre-term and low birth weight infants.[170]

Dental Student Loan Repayment Program

In 2019, the Legislature created the Dental Student Loan Repayment Program under DOH. Under the program, a Florida-licensed dentist is eligible to participate if he or she maintains active employment in

[164] Florida Department of Health, FL Health Charts, available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=326 (last visited January 22, 2024)
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] Chris Collins, MSW, *Challenges of Recruitment and Retention in Rural Areas*, North Carolina Medical Journal, Vol. 77 no. 2, (March-April 2016), http://www.ncmedicaljournal.com/content/77/2/99.full (last visited January 22, 2024).
[169] Florida Department of Health, *Florida's Burden of Oral Disease Surveillance Report*, (Aug, 2016), p. 5, *available at*, http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/floridas-burden-oral-disease-surveillance-report.pdf (last visited January 22, 2024).
[170] *Id.*

a public health program[171] that serves Medicaid recipients and other low-income patients and is located in a dental HSPA or a MUA.[172]

A dentist is no longer eligible to receive funds under the Loan Program if the dentist:[173]

- Is no longer employed by a public health program that is located in a dental HSPA or a MUA and serves Medicaid recipients and other low-income patients;
- Ceases to participate in the Florida Medicaid program; or
- Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of the dental practice act.

DOH is authorized to award each eligible dentist up to $50,000 in student loan repayments per year for up to five years, for a maximum of $250,000. DOH may approve up to 10 new dentists each fiscal year to participate in the Loan Program, in addition to those dentists already participating in the Loan Program.[174]

The Loan Program may only cover loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses and must be made directly to the holder of the loan. All repayments are contingent upon continued proof of eligibility and the state is not responsible for the collection of any interest charges or other remaining loan balances.[175]

Currently, there is no reporting requirement and no requirement to perform an evaluation on the effectiveness of the program.

Effect of the bill - Dental Student Loan Repayment Program

The bill expands eligibility for the Dental Student Loan Repayment Program to include dental hygienists and to include dentists who practice in private dental practices that are located in dental health professional shortage areas. The annual award for a qualifying dentists or dental hygienist is 20 percent of his or her principal loan amount at the time that he or she applies for the program, but may not be more than $50,000 per year for dentists or $7,500 per year for dental hygienists.

The bill requires practitioners to provide 25 hours of volunteer primary care or dental services in a free clinic, as defined in s. 766.1115, F.S., that is located in an underserved area or through another volunteer program operated by the state pursuant to part IV of ch. 110, F.S.

Additionally, the bill requires AHCA to seek federal authority to use Title XIX[176] matching funds for the Dental Student Loan Repayment Program and provides a sunset date for the program of July 1, 2034.

The bill creates s. 381.4021, F.S., to establish reporting requirements for the program. The bill requires DOH to provide an annual report to the Governor and the Legislature that details:

- The number of applicants for loan repayment;
- The number of loan payments made under each program;
- The amounts for each loan payment made;
- The type of practitioner to whom each loan payment was made;
- The number of loan payments each practitioner has received under either program; and
- The practice setting in which each practitioner who received a loan payment practices.

The bill also requires DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness the DSLR Program. The bill requires DOH to begin collecting the data needed by January 1, 2025, and submit the study to the Governor and the Legislature by January 1,

[171] Section 381.4019 defines a "public health program" as a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by DOH.
[172] Section 381.4019, F.S.
[173] *Id.*
[174] *Id.*
[175] *Id.*
[176] Title XIX of the federal Social Security Act creates the Medicaid program and provides federal matching funds for states that participate in Medicaid.

2030. Practitioners who receive payments under the DSLR Program must furnish any information requested by DOH for the study or DOH's annual reporting requirements.

The Florida Reimbursement Assistance for Medical Education Program (FRAME)

In 2002, the Legislature created the Medical Education Reimbursement and Loan Repayment Program (program) within DOH, to encourage health care professionals to practice in underserved areas where there are shortages of such personnel.[177] The program makes payments to offset loans and educational expenses incurred in nursing or medical studies or licensure. Health care professionals eligible to participate in the program include:[178]

- Allopathic physicians with primary care specialties;
- Osteopathic physicians with primary care specialties;
- Physician assistants;
- Autonomous APRNs with primary care specialties;
- Licensed practical nurses;
- Registered nurses; and
- APRNs.

As funds are available, DOH may award up to:[179]

- $20,000 per year for allopathic and osteopathic physicians with primary care specialties;
- $15,000 per year for autonomous APRNs with primary care specialties;
- $10,000 per year for APRNs and physician assistants; and
- $4,000 per year for licensed practical nurses and registered nurses.

To qualify for reimbursement, a health care practitioner must:[180]

- Be a U.S. citizen;
- Possess a clear active Florida health care professional license;
- Provide in-person services to persons in an underserved location;[181]
- Not have received an award from any other State of Florida-funded student loan repayment program since July 1 of the previous year; and
- Have a qualified loan.[182]

An autonomous APRN, in addition to the requirements above, must specifically have active employment providing primary care services in a practice or public health program that serves Medicaid and other low-income patients and practice in a location that has a primary care Health Professional Shortage Area (HPSA)[183] score of at least 18.[184]

During the 2022-2023 fiscal year, 3,702 applications were submitted for loan reimbursement. Of the 3,702 applicants, 1,407 met the program requirements, representing $40.8 million in requested loan forgiveness, which is more than twice the available funding for the program—$16 million. Of the 1,407 applicants who met the program requirements, 1,097 received loan reimbursement awards.[185]

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[177] Section 1009.65(1), F.S.
[178] *Id.* Primary care specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties identified by DOH.
[179] Section 1009.65(1), F.S.
[180] Rule 64W-4.002(1)(a), F.A.C.
[181] Rule 64W-4.001, F.A.C., defines an "underserved location" as a public health program; a correctional facility; a Health Professional Shortage Area as designated by Federal Health Resources and Services Administration in a primary care discipline; a rural area as identified by the Federal Office of Rural Health Policy; a rural hospital as defined in s. 395.602(2)(b), F.S.; a state hospital; or other state institutions that employ medical personnel.
[182] Rule 64W-4.001, F.A.C., defines a "qualified loan" as a federal and/or private student loan with a US-based lender that has a verified balance remaining which loan proceeds were used to pay educational expenses.
[183] S. 1009.65(1)(b)1., F.S., defines "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.
[184] Rule 64W-4.002(1)(b), F.A.C.
[185] Presentation by Emma Spencer, PhD, MPH, Department of Health, on Student Loan Repayment Programs, Florida House of Representatives, Healthcare Regulation Subcommittee, November 16, 2023, at pgs.7-9, available at

Physicians received 81% of the available funding.[186] In determining which applicants receive awards, DOH computes a Frame Prioritization Score using an adjusted HPSA score for the practice location of the provider and the length of employment for the provider.[187]

Currently, there is no reporting requirement and no requirement to perform an evaluation on the effectiveness of the program.

Effect of the bill - The Florida Reimbursement Assistance for Medical Education Program (FRAME)

The bill expands the list of eligible practitioners to include mental health professionals, such as licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists. The bill consolidates autonomous APRNs with the other practitioner types and eliminates specific requirements for such APRNs to qualify for the program. The bill allows reimbursement awards to be provided over a four-year period, instead of on a yearly basis and increases the maximum award amounts for each type of practitioner to up to:

- $150,000 for physicians;
- $90,000 for Autonomous APRNs;
- $75,000 for APRNs and PAs;
- $75,000 for mental health professionals; and
- $45,000 for LPNs and RNs.

A practitioner may only receive an award for one four-year period. At the end of each year that a practitioner participates in the program, DOH must award 25 percent of the practitioner's principal loan amount at the time he or she applied for the program.

The bill requires practitioners to provide 25 hours of volunteer primary care in a free clinic that is located in an underserved area or through another volunteer program operated by the state.

The bill requires AHCA to seek federal authority to use Title XIX matching funds for FRAME, and provides a sunset date of July 1, 2034.

The bill creates s. 381.4021, F.S., to establish reporting requirements for the program. The bill requires DOH to provide an annual report to the Governor and the Legislature that details:

- The number of applicants for loan repayment;
- The number of loan payments made under each program;
- The amounts for each loan payment made;
- The type of practitioner to whom each loan payment was made;
- The number of loan payments each practitioner has received under either program; and
- The practice setting in which each practitioner who received a loan payment practices.

The bill also requires DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness the program. The bill requires DOH to begin collecting the data needed by January 1, 2025, and submit the study to the Governor and the Legislature by January 1, 2030. Practitioners who receive payments under the program must furnish any information requested by DOH for the study or DOH's annual reporting requirements.

https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3246&Session=2024&DocumentType=Meeting+Packets&FileName=hrs+11-16-23.pdf (last visited January 22, 2024).

[186] *Id.* Physicians received $12,897,865, APRNs received $1,763,773, physician assistants received $512,249, registered nurses received $449,971, autonomous APRNs received $302,079, and licensed practical nurses received $73,950.

[187] Rule 64W-4.005(2), F.A.C.

Clinical Psychologists' and Psychiatric Nurses' Authority Under the Baker Act

The Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[188] The Baker Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[189] Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[190]

Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for himself or herself to the extent that such refusal threatens to cause substantial harm to his or her well-being and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to himself or herself or others in the near future based on recent behavior.[191]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[192]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[193] or
- A physician, clinical psychologist,[194] psychiatric nurse,[195] an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the practitioner's observations supporting such conclusion.[196]

Involuntary patients must be taken to either a public or private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[197]

The patient must be examined by a physician, clinical psychologist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist to determine if the patient meets the criteria for involuntary services within 72 hours of the initiation of the involuntary examination.[198] A patient may be released only upon the documented approval of a psychiatrist or clinical psychologist. If the receiving facility is owned or operated by a hospital, health system, or nationally accredited community health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist.

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[188] Sections 394.451-394.47892, F.S.
[189] Section 394.459, F.S.
[190] Sections 394.4625, 394.463, and 394.4655, F.S.
[191] Section 394.463(1), F.S.
[192] Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[193] Section 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[194] Section 394.455(5), F.S., defines a "clinical psychologist" as a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.
[195] Section 394.455(36), F.S., defines a "psychiatric nurse" as a Florida-licensed advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.
[196] Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[197] Section 394.455(40), F.S.
[198] Section 394.463(2)(f)-(g), F.S.

Involuntary Placement

If an individual continues to be in need of services, a treatment facility may petition the court to order either involuntary inpatient treatment or involuntary outpatient treatment for the individual.[199] Any petition for continued involuntary treatment, whether inpatient or outpatient, must be supported by the opinion of a psychiatrist, and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours and determined that the criteria for involuntary services are met.[200] In a hearing on such petitions, a court may issue an order for involuntary outpatient services, involuntary inpatient services, or an involuntary assessment, appoint a guardian, or order the patient's discharge.[201]

Voluntary Admissions

Baker Act receiving facilities may also admit any person 18 years of age or older making application by express and informed consent for admission, or any person age 17 or younger for whom such application is made by his or her guardian.[202] If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, a person 18 years of age or older may be admitted to the facility.[203] A person 17 years of age or younger may only be admitted after a clinical review to verify the voluntariness of the minor's assent.

Psychologists

The practice of psychology is the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[204] Psychological services may be rendered to individuals, couples, families, groups, and the public without regard to place of service.

The Board of Psychology within DOH oversees the licensure and regulation of psychologists in Florida.[205] To be licensed as a psychologist the applicant must:

For licensure by examination:

- Hold a doctoral degree from a program accredited by the American Psychological Association;[206]
- Have at least two years or 4,000 hours of supervised experience in the field of psychology;
- Pass the Examination for Professional Practice in Psychology; and
- Pass an examination on Florida laws and rules.[207]

For licensure by endorsement:

- Be a diplomate in good standing with the American Board of Professional Psychology and pass an examination on Florida laws and rules; or
- Hold a doctoral degree in psychology and have at least 10 years' experience as a licensed psychologist in any U.S. jurisdiction within the preceding 25 years.[208]

Under current law, a "clinical psychologist" is a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for

[199] *See* ss. 394.4655 and 394.467, F.S.
[200] Sections 394.4655(3)-(4), F.S., for involuntary outpatient services, and ss. 394.467(2)-(4), F.S., for involuntary inpatient services.
[201] Section 394.4655(7), F.S., for involuntary outpatient services, and ss. 394.467(6), F.S., for involuntary inpatient services.
[202] Section 394.4625(1)(a), F.S.
[203] *Id*.
[204] Section 490.003(4), F.S.
[205] Section 490.004, F.S.
[206] Alternatively, the applicant may have received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology. The burden is on the applicant to establish that this requirement has been met.
[207] Section 490.005, F.S., and r. 64B19-11.001, F.A.C.
[208] Section 490.006, F.S.

licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.[209]

Psychiatric Nurses

Psychiatric nurses are licensed as advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.[210] The Board of Nursing within DOH oversees the licensure and regulation of advanced practice registered nurses. To obtain license as an advanced practice registered nurse in Florida, the nurse must submit an application and provide proof that he or she; [211]

- Holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing under the Nurse Licensure Compact;
- Is certified by the appropriate specialty board; and
- Has a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills.

For licensure as a psychiatric nurse, the applicant must hold one of the following certifications recognized by the Board of Nursing: [212]

- Psychiatric Mental Health Nurse Practitioner Certification;
- Family Psychiatric and Mental Health Nurse Practitioner;
- Adult Psychiatric and Mental Health Nurse Practitioner; or
- Psychiatric Adult Clinical Nurse Specialist (CNS).

In order to be recognized by the Board of Nursing, each specialty board must attest to the competency of nurses in the clinical specialty area, identify standards or scope of practice statements as appropriate for the specialty, require a written examination for certification, and require completion of a formal program prior to eligibility of examination.[213]

Effect of the bill - Clinical Psychologists' and Psychiatric Nurses' Authority Under the Baker Act

Clinical Psychologists

The bill revises the definition of "clinical psychologist" to remove the three years of experience required under current law and authorizes a licensed clinical psychologist of any experience to:

- Perform an involuntary examination under the Baker Act;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services, if a psychiatrist or clinical psychologist with three years' experience is unavailable;
- Determine if the treatment plan for a patient is clinically appropriate; and
- Provide a second opinion to support a recommendation that a patient receive involuntary inpatient services if a psychiatrist or clinical psychologist with three years' experience is unavailable.

The bill retains a three-year clinical experience requirement for a clinical psychologist to:

- Authorize the transfer of a voluntary patient to an involuntary status;
- Authorize the discharge of a patient;
- Authorize the release of a patient after completion of an involuntary examination;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services;
- Provide a statement to the court in a proceeding justifying a request to continue involuntary outpatient services beyond the time ordered;

[209] Section 394.455, F.S.
[210] Section 394.455, F.S.
[211] Section 464.012(1), F.S.
[212] Rule 64B9-4.002, F.A.C.
[213] *Id*.

- Provide a second opinion to support a recommendation that a patient be involuntarily admitted for inpatient services; and
- Diagnose a child as psychotic or severely emotionally disturbed, if the clinical psychologist has specialty training and experience working with children.

Psychiatric Nurses

The bill revises the definition of "psychiatric nurse" to reduce the experience requirement from two years to one year and authorizes a psychiatric nurse with one year of experience to:

- Prohibit a patient from accessing clinical records if the psychiatric nurse determines such access would be harmful to the patient;
- Determine if the treatment plan for a patient is clinically appropriate;
- Authorize a person who is 14 years of age or older to be admitted to a bed in a room or ward in a mental health unit with an adult if the psychiatric nurse documents that such placement is medically indicated or for safety reasons; and
- Authorize the substitution of medications upon discharge of certain indigent patients if the psychiatric nurse determines such substitution is clinically indicated.

However, the bill requires a psychiatric nurse to be working within the framework of an established protocol with a psychiatrist to perform the following acts:

- Provide an opinion to a court on the competence of an individual to consent to treatment in a proceeding to appoint a guardian advocate;
- For patients voluntarily admitted into a facility, document that a patient is able to give express and informed consent;
- Authorize emergency treatment of a patient if the psychiatric nurse determines that such treatment is necessary for the safety of the patient or others;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services;
- Provide that, in his or her clinical judgment, a patient has failed to comply with involuntary outpatient services and that efforts were made to effect compliance, and thus making the patient subject to an involuntary examination;
- Provide a second opinion to support a recommendation that a patient be involuntarily admitted for inpatient services; and
- Prescribe medications to a patient in a crisis stabilization unit.

Behavioral Health Acute Care System - Mobile Response Teams

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. The behavioral health acute care system is a complex system that includes a variety of entities and integrated components that are essential for providing a public health safety net and comprehensive crisis response system for those with mental health and substance use disorders.

Crisis Response System

A crisis response system is a coordinated set of structures, processes and services put in place to respond to urgent and emerging mental health crisis. The system is designed to connect an individual experiencing a crisis to the appropriate level of care based on the assessed need of the individual. Key components of an effective crisis response system include regional or statewide crisis call centers coordinating in real time, centrally deployed 24/7 mobile crisis response teams, and readily available

crisis receiving and stabilization programs.[214] Florida has various crisis support services that address the different components, including mobile response teams.

Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors and occur at any hour of the day.[215] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[216] Law enforcement or EMTs may be called to respond to mental health crises, and may lack the training and experience to effectively handle the situation.[217] Mobile response teams (MRT) can be beneficial in such instances.

MRTs support the behavioral health crisis response system as these teams travel to the acute situation or crisis to provide assistance. MRTs provide on-demand, community-based crisis intervention services 24 hours a day, seven days per week, in any setting in which a behavioral health crisis is occurring.[218] Mobile response services are typically provided by a team of crisis-intervention trained professionals and paraprofessionals who use face-to-face professional and peer intervention. MRTs are deployed in real time to the location of the person in crisis in order to achieve the best outcomes necessary for that individual, ensuring timely access to assessment, evaluation, support, and other services.[219] MRTs provide a warm handoff to other services, coordinate care, and ensure that the individual is engaged in services. MRTs are required to remained engaged for a minimum of 72 hours to ensure that the individual is actively connected to another service provider.[220]

In 1996, the Legislature integrated mobile crisis response services into Part I of ch. 394, F.S., the Florida Mental Health Act and authorized DCF to adopt rules establishing the minimum standards for services provided and for the personnel employed by a mobile crisis response service.[221] Under Part 1 of ch. 394, F.S., mobile crisis response services, such as MRTs, are contracted through DCF and provide general onsite behavioral health crisis services to persons of all ages in various capacities throughout the state.

DCF rules lists the minimum standards that authorized mobile crisis response service providers must adhere to.[222] The minimum standards list broad requirements and serve as a guideline for providers to use when establishing policy and procedures for operation of mobile crisis response services. Authorized service providers are required to establish and enforce a DCF-approved policy and procedures manual for the specific service being provided. The manual must be consistent with the provisions of Part I of ch. 394, F.S., and include processes and procedures to address the minimum standards specified in rule.[223] A few of the standards that must be included in the manual are:[224]

- A description of the services offered, eligibility criteria, how eligible recipients are informed of service availability, criteria for response, hours of operation, staffing with staff qualifications and supervision, and organizational line of authority to the operating entity;
- Procedures for mechanisms to monitor and evaluate service quality and the outcomes attained by individuals served;
- Procedures to determine whether the individual being served has a case manager from a mental health center or clinic, and procedures requiring notification and coordination of activities with the case manager;
- Procedures to implement voluntary admissions provisions; and

[214] Substance Abuse and Mental Health Services (SAMHSA), *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, available at https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf, (last visited January 22, 2024)
[215] Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4 https://myflfamilies.com/sites/default/files/2022-12/Mobile%20Response%20Framework.pdf (last visited January 22, 2024).
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).
[221] Chapter 1996-169, Laws of Florida and s. 394.457, F.S.
[222] Rule 65E-5.400(6), F.A.C.
[223] *Id.*
[224] *Id.*

- Procedures for transporting individuals subject to involuntary examination.

In 2020, the Legislature required crisis response services be provided through MRTs under Part III of ch. 394, F.S., (Comprehensive Child and Adolescent Mental Health Services).[225] This requires DCF to contract with the managing entities[226] to procure mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18-25, inclusive, who:[227]

- Have an emotional disturbance;
- Are experiencing an acute mental or emotional crisis;
- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function normally within their environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

Part III of ch. 394, F.S., lists specific and detailed requirements for MRTs. Under Part III of ch. 394, F.S., MRTs are required to:

- Triage new requests to determine the level of severity and prioritize new requests that meet the clinical threshold for an in-person response and provide in-person responses to such calls meeting the clinical level of response within 60 minutes after prioritization;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family;
- Provide evidence-based practices to children, adolescents, young adults, and families to enable them to de-escalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure there is a process in place for informed consent and confidentiality compliance measures;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the applicable managing entity to establish informal partnerships with key entities providing behavioral health services and supports to children, adolescents, or young adults and their families to facilitate continuity of care.

In Fiscal Year (FY) 2022-23, DCF received additional funding for MRTs under Part III of ch. 394, F.S., allowing for the implementation of 12 new MRTs and the expansion of 30 existing children's teams. Currently there are 51 MRTs serving all 67 counties in Florida.[228] During FY 2022-23, the MRTs received a total of 28,294 calls and served 22,435 individuals.[229] A recent review of MRT data from 2019 through 2022 shows that approximately 82 percent of MRT engagements resulted in community stabilization rather than involuntary admission or deeper penetration into the behavioral health system.[230]

[225] See Chapter 2020-107, L.O.F.
[226] DCF contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state. Currently, the DCF contracts with seven MEs. *See* Department of Children and Families, *Managing Entities, available at* https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited January 22, 2024).
[227] S. 394.495(7)(a), F.S.
[228] DCF, Agency *Legislative Budget Request for Fiscal Year 2024-2025*, available at http://floridafiscalportal.state.fl.us/Document.aspx?ID=26122&DocType=PDF , (last visited January 22, 2024).
[229] DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).
[230] Department of Children and Families, *Triennial Plan for the Delivery of Mental Health and Substance Abuse Services: State Fiscal Years 2023-2024 and 2025-2026, pg. 6, available at* https://www.google.com/url?client=internal-element-cse&cx=b5f7422ffe5734ed7&q=https://www.myflfamilies.com/sites/default/files/2023-06/Substance%2520Abuse%2520%2526%2520Mental%2520Health%2520Services%2520Triennial%2520State%2520and%2520Regional%2520Master%2520Plan%2520%25202023-2025.pdf (last visited Nov. 28, 2023).

Effect of the bill - Behavioral Health Acute Care System - Mobile Response Teams

The bill requires the minimum standards for the general mobile crisis response services under Part I of ch. 394, F.S., to include the mobile crisis response service and MRT standards established under Part III of ch. 394, F.S., for children, adolescents, and young adults. The bill also requires the minimum standards for general MRTs under Part 1 of ch. 394, F.S., to ensure coverage for adults over age 25 in all counties and to focus on rapid crisis intervention, emergency room diversion, the provision of and referral to services that are responsive to the needs of the individuals in crisis and his or her family. Further the bill implements follow-up procedures requiring MRTs to follow-up with the individual at 90 and 180 days to gather outcome data on the mobile crisis response encounter to determine the effectiveness of the mobile crisis response services that were provided.

While the mobile crisis response service and MRT provisions under Parts I and III of ch. 394, are not in conflict, the bill aligns the requirements and performance expectations between the two types of MRTs, while preserving the focus of MRTs serving children, adolescents, and young adults under Part III of ch. 394. The alignment of these standards will require changes to existing DCF rules to include the MRT standards under Part III of ch. 394, F.S., and implement the additional MRT minimum standard provisions of the bill.

The terms "mobile crisis response service" and "mobile response teams" are used interchangeably throughout Parts I and III. The bill amends s. 394.455, F.S. to make it clear that the terms "mobile crisis response service" and "mobile response team" have the same meaning.

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[231] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[232]

Every U.S. state requires at least one year of residency training to receive an unrestricted license to practice medicine, and some require two or three years. However, most physicians train beyond the minimum licensure requirement in order to become board certified in a "pipeline" specialty (i.e., those that lead to initial board certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the number of U.S. residency slots has been larger than the number of U.S. medical graduates, so residency programs were filled in part by graduates of non-U.S. medical schools (including both U.S. and non-U.S. citizens). Now, with growth in the number and size of medical schools, the number of U.S. medical graduates is beginning to more closely approximate the current number of residency slots. In a recent survey conducted by the Association of American Medical Colleges (AAMC), 122 of 130 responding medical school deans reported some concern about the number of post-graduate training opportunities for their students.[233]

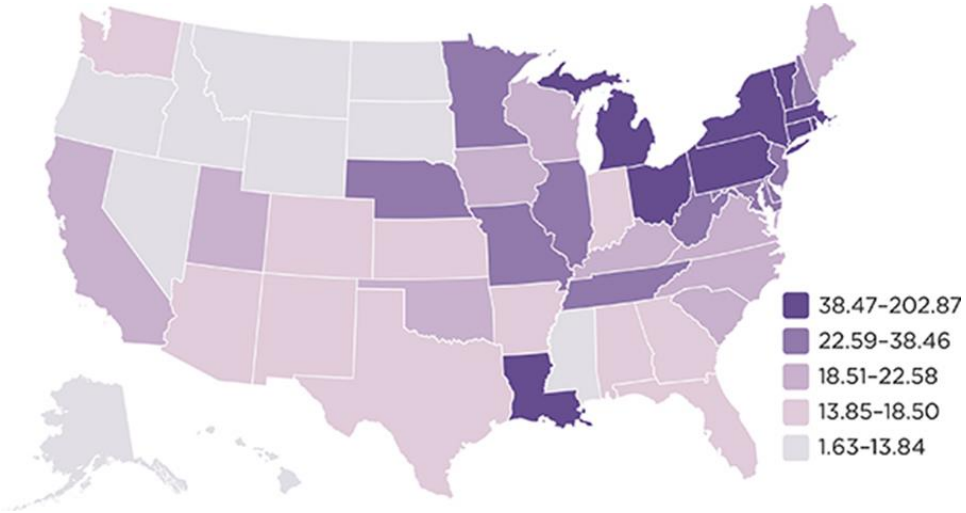
Medicare Funding of GME

GME is largely funded through both the Medicare and the Medicaid programs. Until the enactment of the Balanced Budget Act (BBA) of 1997, Medicare support of GME was open-ended. Before the BBA, hospitals had a strong financial incentive to add new residency slots because each new position generated additional Medicare per-resident amount and indirect medical education revenues. In

[231] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited January 22, 2024).
[232] *Id.*
[233] *Id.*

response to concerns about an oversupply of physicians and increasing Medicare costs, the BBA capped the number of Medicare-supported physician training slots.[234]

Hospitals are free to add residents beyond their cap, but these trainees do not generate additional Medicare revenues. The cap on Medicare funding was set at each hospital's resident count in the cost report period ending on or before December 31, 1996. With this step, the geographic distribution of Medicare-supported residencies was essentially frozen in place without regard for future changes in local or regional health workforce priorities or the geography or demography of the U.S. population. As can be seen by the following chart (showing the number of Medicare-funded training positions per 100,000 population), Medicare-supported slots are most highly concentrated in the Northeastern states, as is most of Medicare GME funding.[235]



Medicaid Funding of GME

GME is an approved component of Medicaid inpatient and outpatient hospital services.[236] If a state Medicaid program opts to cover GME costs, the federal government provides matching funds.[237] Florida opts to fund GME through the Statewide Medicaid Residency Program (SMRP).[238] For fiscal year 2023-2024, the SMRP funded 6,176 residents at 83 location.[239]

The SMRP allows both hospitals and Federally Qualified Health Centers (FQHC) that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) to qualify for GME funding. In addition to the SMRP, the Legislature has allocated additional funding to GME through the Startup Bonus Program and the Slots for Doctors Program.

Startup Bonus Program (SBP)[240]

The SBP was established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. The program allocates a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).[241]

[234] *Id.*
[235] *Id.*
[236] *Id.*
[237] *Id.*
[238] Section 409.909, F.S.
[239] SFY 2023-24 Statewide Medicaid Residency Program Distribution, AHCA, available at https://ahca.myflorida.com/content/download/23217/file/SFY%2023-24%20GME%20SMRP%20Calculation%20Clean.pdf, (last visited January 22, 2024).
[240] Section 409.909(5), F.S.
[241] Chapter 2023-239, Laws of Florida

The Slots for Doctors Program (SDP)

The SDP requires the AHCA to annually allocate $100,000 to hospitals and qualifying institutions for each newly created slot that is first filled on or after June 1, 2023, and remains filled thereafter.[242] The new slot must be accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit. The sections specify that the program is designed to generate matching funds under the Medicaid program and distribute those funds to participating hospitals and qualifying institutions and that specialties and sub-specialties are those that are identified in the GAA.

Specialties and Sub-Specialties in Supply and Demand Deficit

The 2023-24 GAA lists the following specialties and subspecialties as being in supply-and-demand deficit:

- Allergy or immunology;
- Anesthesiology;
- Cardiology;
- Colon and rectal surgery;
- Emergency medicine;
- Endocrinology;
- Family medicine;
- Gastroenterology;
- General internal medicine;
- Geriatric medicine;
- Hematology;
- Oncology;
- Infectious diseases;
- Neonatology;
- Nephrology;
- Neurological surgery;
- Obstetrics/gynecology;
- Ophthalmology;
- Orthopedic surgery;
- Pediatrics;
- Physical medicine and rehabilitation;
- Plastic surgery/reconstructive surgery;
- Psychiatry;
- Pulmonary/critical care;
- Radiation oncology;
- Rheumatology;
- Thoracic surgery;
- Urology; and
- Vascular surgery.

Ohio's Primary Care Workforce Initiatives (OPCWI)

The goal of the OPCWI is to expose health professional students to patient centered medical homes (PCMHs) and provide a standardized, high-quality educational experience while providing support for the administrative costs and decrease in revenue typically associated with hosting and training students. To accomplish this, the OPCWI provides training and technical support for preceptors and compensates participating health centers such as FQHCs, not preceptors, for the time their staff spend teaching students.

[242] Section 409.909(6), F.S.

Health centers may host students in the following disciplines: medicine, dentistry, advanced practice nursing, physician assisting, and behavioral health. These structured clinical experiences are designed to increase primary care capacity in some of the most underserved neighborhoods in Ohio. Located throughout the state, Ohio's FQHCs serve over 850,000 Ohioans each year. Participating health centers have, or commit to obtaining, national recognition as PCMHs so that students can experience an advanced primary care practice model.[243]

The OPCWI pays quarterly at an hourly rate determined by the type of provider:[244]

1st Year Med. Student	$27/hr.
2nd Year	$27/hr.
3rd Year	$29/hr.
4th Year	$29/hr.
Dentist	$22/hr.
APRN	$22/hr.
PA	$22/hr.
Behavioral Health	$15/hr.

Effect of the bill - Graduate Medical Education

The bill amends SDP to allow the AHCA to fund up to 200 residency slots that were in existence prior to July 1, 2023, as long as those slots:

- Are in a physician specialty or subspecialty experiencing a statewide supply-and-demand deficit;
- Have been unfilled for a period of 3 or more years;
- Are subsequently filled on or after June 1, 2024, and remain filled thereafter; and
- Are accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program.

Additionally, the bill specifies that if there are more applicants for the SDP than there is available funding or number of authorized slots, the AHCA must prioritize positions that are in primary care, as specified in paragraph (2)(a).

Reporting Requirements

The bill amends s. 409.909, F.S., to require any hospital or qualifying institution[245] that receives state funds under the SMRP, including, but not limited to intergovernmental transfers, to annually report data to the AHCA.

Specific to funds allocated other than from the Startup Bonus Program, the bill requires the data to include, at a minimum:

- The sponsoring institution for the resident position. As used in this section, the term "sponsoring institution" means an organization that oversees, supports, and administers one or more resident positions.
- The year the position was created and the current program year of the resident who is filling the position.
- Whether the position is currently filled and whether there has been any period of time when it was not filled.
- The specialty or subspecialty for which the position is accredited and whether the position is a fellowship position.

[243] Y8 Ohio Primary Care Workforce Initiative (OPCWI) User Manual, Ohio Association of Community Health Centers, available at Y8_OPCWI_User_Manual.pdf (ymaws.com), (last visited January 22, 2024).
[244] *Id.* at p. 6.
[245] A qualifying institution is defined in s. 409.909, F.S., as a federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation.

If the funds were allocated under the Startup Bonus Program on or after July 1, 2021, the data must include:

- The date on which the hospital or qualifying institution applied for funds under the program.
- The date on which the position funded by the program became accredited.
- The date on which the position was first filled and whether it has remained filled.
- The specialty of the position created.

Additionally, beginning July 1, 2025, each hospital or qualifying institution is required to annually produce detailed financial records no later than 30 days after the end of its fiscal year that detail the manner in which state funds were allocated under the SMRP were expended. The bill exempts funds that were allocated before July 1, 2025. The AHCA is also authorized to require that any hospital or qualifying institution submit to an audit of its financial records related to funds allocated under the SMRP after July 1, 2025.

If a hospital or qualifying institution fails to produce any of the required information or records, the hospital or qualifying institution is no longer eligible to participate in any Medicaid GME program until the AHCA has determined it has produced the records.

Residency Exit Survey

The bill requires that each qualifying institution and hospital must request an exiting resident to fill out an exit survey on a form developed by the AHCA. The surveys must be provided annually to the AHCA and must include, at a minimum, questions on:

- Whether the exiting resident has procured employment.
- Whether the exiting resident plans to leave the state and, if so, for which reasons.
- Where and in which specialty the exiting resident intends to practice.
- Whether the exiting resident envisions himself or herself working in the medical field as a long-term career.

Graduate Medical Education Committee (GMEC)

The bill establishes the GMEC within the AHCA. The committee will be made up of:

- Three deans, or their designees, from medical schools in this state, appointed by the chair of the Council of Florida Medical School Deans.
- Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association, one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under ch. 458 or ch. 459, F.S., practicing at a qualifying institution.
- Two members appointed by the Secretary of the Agency for Health Care Administration, one of whom represents a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents.
- Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents or interns.
- Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

The bill specifies that the members who are medical school deans will serve four-year terms and rotate membership through the medical schools in Florida. Otherwise, members serve four-year terms with the initial terms being three or two years for specified members in order to stagger changes of membership. The GMEC must elect a chair to serve for a one-year term and members are required to serve without compensation but are entitled to reimbursement for per diem.

The bill requires the committee to convene its first meeting by July 1, 2024, and to meet at least twice annually at the call of the chair. Meetings may be conducted electronically with a majority of the members representing a quorum.

Beginning July 1, 2025, the committee is required to submit an annual report to the Governor and the Legislature detailing:

- The role of residents and medical faculty in the provision of health care.
- The relationship of graduate medical education to the state's physician workforce.
- The typical workload for residents and the role such workload plays in retaining physicians in the long-term workforce.
- The costs of training medical residents for hospitals and qualifying institutions.
- The availability and adequacy of all sources of revenue available to support graduate medical education.
- The use of state funds, including, but not limited to, intergovernmental transfers, for graduate medical education for each hospital or qualifying institution receiving such funds.

The bill requires the AHCA to provide reasonable and necessary support staff and materials to the committee, to provide the information obtained from the reporting requirements created by the bill, and to assist the committee in obtaining any other information necessary to produce its report.

Training, Education, and Clinicals in Health (TEACH) Funding Program

The bill creates s. 409.91256, F.S., to establish the TEACH Funding Program. The program is created to provide a high-quality educational experience while supporting participating federally qualified health centers, community mental health centers, rural health clinics, and certified community behavioral health clinics by offsetting administrative costs and loss of revenue associated with training residents and students to become licensed health care practitioners. The bill provides legislative intent that the program be used to support the state Medicaid program and underserved populations by expanding the available health care workforce.

The bill defines the following terms:

- "Preceptor" to mean a Florida-licensed health care practitioner who directs, teaches, supervises, and evaluates the learning experience of a resident or student during a clinical rotation.
- "Primary care specialty" to mean general internal medicine, family medicine, obstetrics and gynecology, general pediatrics, psychiatry, geriatric medicine, or any other specialty the agency identifies as primary care.
- "Qualified facility" to mean an FQHC, community mental health center, rural health clinic, or certified community behavioral health clinic.

The bill requires the AHCA to develop an application process for qualified facilities to apply for funds to offset administrative costs and loss of revenue associated with establishing, maintaining, or expanding a clinical training program.

Once an application is approved, the AHCA is required to enter into an agreement with the qualified facility that requires the facility to, at a minimum:

- Agree to provide appropriate supervision or precepting for one or more of:
    - Allopathic or osteopathic residents pursuing a primary care specialty.
    - Advanced practice registered nursing students pursuing a primary care specialty.
    - Nursing students.
    - Allopathic or osteopathic medical students.
    - Dental students.
    - Physician assistant students.
    - Behavioral health students, including students studying psychology, clinical social work, marriage and family therapy, or mental health counseling.

- Meet and maintain all requirements to operate on accredited residency program if the qualified facility operates a residency program.
- Obtain and maintain accreditation from an accreditation body approved by the AHCA if the qualified facility provides clinical rotations.
- Ensure that clinical preceptors meet AHCA standards for precepting students, including any required training.
- Provide preference for residents and students enrolled in Florida schools or whose state of legal residence is Florida.
- Submit quarterly reports to the AHCA by the first day of the second month following each quarter which must, at a minimum, include:
- The type of residency or clinical rotation offered by the qualified facility, the number of residents or students participating in each type of clinical rotation or residency, and the number of hours worked by each resident or student each month.
- Evaluations by the residents and student participants of the clinical experience on an evaluation form developed by the agency.
- An itemized list of administrative costs associated with the operation of the clinical training program, including accreditation costs and other costs relating to the creation, implementation, and maintenance of the program.
- A calculation of lost revenue associated with operating the clinical training program.

The bill requires the AHCA, in consultation with the DOH to develop, or contract for, training for preceptors and make such training available in either a live or electronic format. The AHCA is also required to provide technical support for preceptors.

Qualified facilities may be reimbursed to offset the administrative costs or lost revenue associated with training students and residents who are enrolled in an accredited educational or residency program in Florida. Subject to appropriation, the AHCA may reimburse a qualified facility based on the number of clinical training hours reported at the following rates:

- A medical resident at a rate of $50 per hour.
- A first-year medical student at a rate of $27 per hour.
- A second-year medical student at a rate of $27 per hour.
- A third-year medical student at a rate of $29 per hour.
- A fourth-year medical student at a rate of $29 per hour.
- A dental student at a rate of $22 per hour.
- An APRN student at a rate of $22 per hour.
- A PA student at a rate of $22 per hour.
- A behavioral health student at a rate of $15 per hour.

A qualified facility may not be reimbursed more than $75,000 per fiscal year or $100,000 if the facility operates a residency program.

A qualified facility that receives payments under the program must provide information to the AHCA for the purpose of the AHCA's reporting requirements in the bill. The AHCA is required to submit an annual report to the Governor and the Legislature, with the first report due by December 1, 2025, detailing, at a minimum:

- The number of students trained in the program, by school, area of study, and clinical hours earned.
- The number of students trained and the amount of program funds received by each participating federally qualified health center or certified community behavioral health clinic.
- The number of program participants found to be employed by a federally qualified health center or a certified community behavioral health clinic or in a federally designated health professional shortage area upon completion of their education and training.
- Any other data the agency deems useful for determining the effectiveness of the program.

The bill also requires the AHCA to contract with an independent third party to develop and conduct a study to evaluate the impact of the TEACH program, including, but not limited to the program's effectiveness in enabling qualified facilities to provide opportunities for clinical rotations and residencies and enabling the recruitment and retention of health care professionals in geographic and practice areas that have experienced shortages. The bill requires the AHCA to begin collecting data by January 1, 2025, and submit the study to the Governor and the Legislature by January 1, 2030.

The AHCA is authorized to adopt rules to implement the program and is required to seek federal approval to use Title XIX matching funds for the program.

The program sunsets on July 1, 2034, under the bill.

Offshore Usage of Clinical Training Opportunities

One problem facing Florida medical schools seeking to increase their student body is a lack of availability of clinical training opportunities. According to a new AAMC (Association of American Medical Colleges) report, 84 percent of medical school deans were concerned about the number of clinical training sites for medical school students even before the COVID-19 pandemic.

More than 70 percent of surveyed deans worried about having enough qualified specialty preceptors, and the response jumped to 87 percent for primary care preceptors. One reason for this is an increase in competition for clinical training opportunities from offshore medical schools. Such offshore medical schools may not be able to offer core clinical experiences where they are located. Instead they rely on training sites within the United States. In order to secure these sites, offshore medical schools will often pay the clinical locations such as hospitals in order to place their students there. Although most U.S. medical schools do not pay hospitals or other settings for clinical training, the AAMC survey of deans found that 44 percent of respondents felt moderate to severe pressure to do so.[246]

Effect of the bill - Offshore Usage of Clinical Training Opportunities

The bill amends s. 395.1055, F.S., to prohibit a hospital from accepting any payment from a medical school directly, or indirectly, related to allowing students from the medical school to obtain clinical hours or instruction at the hospital.

The Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[247] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[248]

Medicaid Provider Enrollment

Federal exceptions excluded, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Practices must be fully operational before they can be enrolled as Medicaid providers. Every entity that provides Medicaid services to enrollees and all third-party software vendors offering services of any kind to providers must enroll as a Medicaid provider.[249]

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[246] *So Many Medical Students, so Few Clerkship Sites*, AAMCNEWS, Sep. 10, 2020, available at https://www.aamc.org/news/so-many-medical-students-so-few-clerkship-sites#:~:text=According%20to%20a%20new%20AAMC,sites%20even%20before%20the%20pandemic., (last visited January 22, 2024).
[247] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited January 22, 2024).
[248] Section 20.42, F.S.
[249] Florida Agency for Health Care Administration & Gainwell Technologies, *Florida Medicaid Provider Enrollment Application Guide, available at* https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/Florida%20Medicaid%20Provider%20Enrollment%20App%20Guide.pdf (last visited January 22, 2024).

The AHCA and its fiscal agent, Gainwell Technologies, develop comprehensive education materials, including reference guides, to assist applicants with the enrollment process, as well as answer the questions of any providers interested in Medicaid enrollment, published on their respective websites.[250]

Statewide Medicaid Managed Care

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid enrollees receive their services through a managed care plan contracted with the AHCA under SMMC.[251]

SMMC has three components: MMA, Long-Term Care (LTC), and Dental. Florida's SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in s. 409.973, F.S., and s. 409.98, F.S.[252] MMA plans provide preventive, acute, behavioral, therapeutic pharmacy, and transportation services to eligible recipients.[253]

Qualifying Community-Based Mobile Crisis Intervention Services

Section 9813 of the federal American Rescue Plan Act of 2021 (ARPA) amended Title XIX of the Social Security Act (Act) to add a new section 1947, authorizing states to provide qualifying community-based mobile crisis intervention services during the period beginning April 1, 2022, and ending March 31, 2027. States with approved coverage and reimbursement authority can receive 85 percent federal match for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which they meet the federally outlined conditions. States are permitted to disregard the provider agreement requirements at s. 1902(a)(27) of the Act that obligate states to enter into provider agreements with "every person or institution providing services under the State plan."[254]

The Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration both describe mobile crisis services as readily available 24 hours a day, and seven days a week services that can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call to respond. The team may be composed of professionals and paraprofessionals, including trained peer support providers, who are educated in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis.[255]

Primary Care Initiative Program

At present, plans operating in the MMA component of SMMC must establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan is required to:[256]

- Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider;
- Assist new Medicaid enrollees in scheduling an appointment with a primary care provider within 30 days after enrollment in the plan, if possible;

[250] *Id.*
[251] Section 20.42, F.S.
[252] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited January 22, 2024).
[253] Florida Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program, available at* https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf (last visited January 22, 2024).
[254] *Centers for Medicare & Medicaid Services, SHO # 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, available at* https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf (last visited January 22, 2024).
[255] *Id.*
[256] Section 409.973(4), F.S.

- Report to the AHCA the number of enrollees assigned to each primary care provider within the plan's network;
- Report to the AHCA the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment; and
- Report to the AHCA the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Medicaid Encounter Data System

Currently, the AHCA operates a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in a managed care plan. Each plan must comply with the AHCA's reporting requirements for the Medicaid Encounter Data System, submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act (HIPAA) provisions for electronic claims, and submit encounter data in accordance with deadlines established by the AHCA. The managed care plans must certify the reported data is accurate and complete.[257]

The AHCA is responsible for validating the data submitted by the plans and has developed methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of SMMC enrollees to allow comparison of service utilization among plans and against expected levels of use. Presently, the analysis is used to identify possible cases of inappropriate service utilization, such as higher-than-expected emergency department encounters[258] or PPEs, to improve access to quality health care services while also reducing expenditures.[259]

Florida's Health Information Exchange Program

Founded in 2011, the Florida Health Information Exchange (FHIE) facilitates the secure statewide exchange of health information between health care providers, hospital systems, and payers. The AHCA governs the FHIE by establishing policy, convening stakeholders, providing oversight, engaging federal partners, and promoting the benefits of health information technology.

The FHIE electronically makes patient health information available to doctors, nurses, hospitals, and health care organizations when needed for patient care. The exchange of patient information is protected through strict medical privacy and confidential procedures. The FHIE is designed to improve the speed, quality, safety, and cost of patient care.[260]

As part of the AHCA's FHIE Services, Florida has developed an Encounter Notification Service (ENS) that delivers real-time notifications based off of Admit, Discharge, and Transfer (ADT) data from participating health care facilities. This data is provided to authorize health care entities to improve patient care coordination. Over 8 million monthly alerts are being sent and more than 700 data sources are presently using ENS, including:

- 95 percent of Licensed Acute Care Hospitals
- 225 Skilled Nursing Facilities
- 64 Urgent Care Centers
- 22 Hospice Providers
- 5 Crisis Stabilization Units
- Statewide Emergency Medical Services Treat-and-Release Providers
- All 67 County Health Departments.[261]

[257] Section 409.967(2)(e), F.S.
[258] *Id.*
[259] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[260] AHCA analysis document, on file with Senate Health Policy Committee staff.
[261] *Id.*

Hospitals that receive Low Income Pool funding are required to participate in the FHIE's Encounter Notification Service, and Medicaid Managed Care Plans also participate as part of their contractual agreements. To participate as subscribers of the ENS service, the AHCA has a standard rate per organization type. The lowest fees are $500 per year for less than 5,000 subscribed patients. Other payment structures vary with the highest minimum annual fee not exceeding $7,500.

FHIE services support public health activities, including real-time reporting of inpatient hospital stays for syndromic surveillance, data sharing with county health departments, emergency medical services, and identified health care registries.

Although data sharing has grown and improved over time, there are several providers not sharing complete data sets due to various reasons such as workflow issues or turnover of staff that is familiar with FHIE needs. The incomplete data limits the ability for subscribers of ENS to have a complete picture of patient care. The incomplete data negatively impacts the AHCA's public health partners who are receiving data through the Florida HIE Services.[262]

Effect of the bill - Florida's Health Information Exchange Program

The bill requires each hospital that maintains a certified electronic health record technology to make available its admit, transfer, and discharge data to the FHIE program for the purpose of supporting public health data registries and patient care coordination. The bill authorizes the AHCA to adopt rules to implement this provision.

Emergency Department (ED) Diversion

Emergency Department Diversion

Hospitals are licensed and regulated by the Agency for Health Care Administration (AHCA) under part I of ch. 395, F.S. In Florida, emergency departments (EDs) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[263] Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide care, treatment, or surgery to relieve or eliminate the emergency medical condition.[264]

Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition.[265] CMS can issue civil monetary penalties to hospitals and physicians for each violation of this provision and can exclude a physician from participation in any federal health care program.[266] The penalty amounts are adjusted annually for inflation. Penalty amounts for the 2023 calendar year are as follows:

- $129,232 for a hospital or responsible physician in a hospital with more than 100 beds; and
- $64,618 for a hospital or responsible physician in a hospital with fewer than 100 beds.[267]

Pursuant to CMS guidance on EMTALA regulations, hospitals should not delay providing a medical screening examination or necessary stabilizing treatment by inquiring about an individual's ability to pay for care.[268] However, hospitals may follow reasonable registration processes for individuals presenting

[262] *Id.*
[263] Section 395.002(13), F.S.
[264] Section 395.1041, F.S.
[265] 42 U.S.C. §1395dd and 42 C.F.R, § 489.24.
[266] 42 C.F.R., § 1003.510
[267] 42 C.F.R., § 102.3
[268] CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Interpretive Guidelines for §489.24(d)(4)(i),(ii),(iii) and (iv), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf (last visited January 22, 2024).

with an emergency medical condition. Reasonable registration processes may include asking whether an individual is insured and, if so, what the insurance is, as long as the inquiry does not delay screening, treatment or unduly discourage the individual from remaining for further evaluation.

Avoidable emergency department visits put a significant strain on the health care system by increasing overall costs and leading to ED overcrowding.[269] A large proportion of all ED visits in the U.S. are for non-urgent conditions,[270] potentially as high as 37 percent.[271] A study estimated that annual savings of $4.4 billion could be achieved if non-urgent ED visits were cared for in retail clinics or urgent care centers.[272] Some of the known drivers attributed to ED overuse are indigent populations, such as Medicaid enrollees, as well as others who may lack health insurance and access to timely and quality care, leaving hospitals with the financial and legal obligation to stabilize all patients who arrive in the ED.[273]

Florida has attempted to address the problem of inappropriate ED use in the past.[274] For example, the insurance code requires insurers and health maintenance organizations (HMOs) to have ED diversion programs and provide information to consumers about alternatives to the ED, and authorizes them to charge higher copayments for primary care services in an ED.[275] Similarly, current law authorizes hospitals to develop ED diversion programs, but does not require them to do so. Such programs can include a hotline to help patients determine where to seek treatment, and a "fast track" program allowing nonemergency patients to seek treatment at a different location.[276]

Urgent Care Centers

An urgent care center is a facility or clinic that provides immediate but not emergent ambulatory medical care to patients.[277] There is no licensure program specifically for urgent care centers. A hospital-owned urgent care center can operate under the license of the hospital. A physician-owned urgent care center is required to be licensed as a health care clinic, unless it meets one of the exemptions contained in s. 400.9905, F.S.

Federally Qualified Health Centers

A Federally Qualified Health Center (FQHC), also known as a community health center, is a federally funded safety net provider that provides primary and preventive health services.[278] FQHCs integrate access to primary care, pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care.[279] There are 776 FQHCs in Florida.[280]

Effect of the bill - Emergency Department (ED) Diversion

The bill requires all hospitals with EDs, including hospital-based off-campus EDs, to submit a diversion plan to AHCA for assisting patients with gaining access to appropriate care settings when such patient presents at the ED with non-emergent health care needs or indicate when receiving triage or treatment at the hospital that they lack regular access to primary care. Starting July 1, 2025, the plan must be approved by AHCA prior to first licensure or licensure renewal. The bill requires all hospitals to submit

[269] Uscher-Pines L, Pines J, Kellermann A, Gillen E, Mehrotra A. Emergency department visits for nonurgent conditions: systematic literature review. Am J Manag Care. 2013 Jan;19(1):47-59. PMID: 23379744; PMCID: PMC4156292.
[270] Non-urgent conditions are typically defined as conditions for which a delay in treatment of several hours would not increase the likelihood of an adverse outcome.
[271] *Supra*, note 273.
[272] Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Aff (Millwood). 2010 Sep;29(9):1630-6. doi: 10.1377/hlthaff.2009.0748. PMID: 20820018; PMCID: PMC3412873.
[273] The Journal of Urgent Care Medicine, *Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program, available at* https://www.jucm.com/reducing-low-acuity-preventable-emergency-room-visits-by-utilizing-urgent-care-center-services-via-mobile-health-unit-diversion-program/ (last visited January 22, 2024).
[274] The Legislature specifically found that the costs of inappropriate utilization of ED services are ultimately borne by the hospital, the insured patients, and state taxpayers, and declared that providers and insurers must share the responsibility of providing alternative treatment options to urgent care patients through consumer education and implementation of mechanisms result in a decrease in ED overutilization. S. 641.31097, F.S.
[275] Sections 627.6405, 641.31097, F.S.
[276] Section 395.1041(7), F.S.
[277] Section 395.002(30), F.S.
[278] 42 U.S.C. §254b.
[279] U.S. Health Resources & Services Administration, *What is a Health Center?*, available at https://bphc.hrsa.gov/about-health-centers/what-health-center (last visited January 22, 2024).
[280] U.S. Health Resources & Services Administration, *FQHCs and LALs by State*, available at https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs (last visited January 22, 2024).

data to AHCA demonstrating the effectiveness of its ED diversion plan annually and update the plan as necessary, or as directed by AHCA, prior to licensure renewal.

The ED diversion plan must include at least one of the following:

- A partnership agreement with one or more nearby FQHC or other primary care settings. The goal of the agreement must include, but need not be limited to:
  - Identifying patients who present at the ED for non-emergent care, care that would best be provided in a primary care setting, or emergency care that could potentially have been avoided through the regular provision of primary care; and
  - Establishing a relationship between the patient and the FQHC or other primary care setting so that the patient develops a medical home at such setting for non-emergent and preventative health care services.
- The establishment, construction, and operation of a hospital-owned urgent care center adjacent to the hospital ED or an agreement with an urgent care center located within three miles in an urban area or 10 miles in a rural area. The hospital must seek to divert to the urgent care center those patients who present at the ED needing non-emergent health care services and subsequently help those patients obtain primary care.

Additionally, the bill requires the ED diversion plan to include outreach to a patient's managed care plan and coordination with the plan to establish a relationship between the patient and a primary care setting. The bill requires AHCA to establish a process for the hospital to share the patient's updated contact information with the managed care plan.

Potentially Preventable Health Care Events (PPEs)

PPEs are encounters that could be prevented but lead to unnecessary health care services.[281]

Potentially Preventable Hospital Emergency Department Visits

Potentially preventable hospital emergency department visits happen when a patient seeks services at an emergency department for a health condition that could have been prevented or treated in a non-emergency setting.[282] The AHCA has identified a variety of causes that may result in these visits, e.g., failure to access primary care, lack of ambulatory care coordination, monitoring, or follow-up, inadequate and/or inaccessible nursing care for a nursing sensitive condition, etc.[283]

Throughout federal fiscal year (FFY) 2019-2020, 294,220 potentially preventable emergency department visits were identified, compared to 388,257 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[284]

- Upper respiratory infections/otitis;
- Gastrointestinal diagnoses;
- Skin traumas;
- Abdominal pain;
- Viral illnesses;
- Level II musculoskeletal diagnoses;
- Level I respiratory diagnoses;
- Lower urinary tract infections;
- Skin tissue conditions; and

[281] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[282] *Id.*
[283] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[284] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Emergency Room Visits (PPVs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPVsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).

- Fevers.

Potentially Preventable Hospital Admissions

Potentially preventable hospital admissions are when a patient is admitted for necessary treatment to an acute care hospital[285], but the admission could have been avoided, or when a patient is admitted and could have been treated outside of an inpatient hospital setting.[286]

Throughout federal fiscal year (FFY) 2019-2020, 71,541 potentially preventable hospital admissions were identified, compared to 67,048 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[287]

- Septicemia;
- Heart failure;
- Pneumonia diagnoses;
- Chronic obstructive pulmonary disease;
- Major respiratory infections;
- Infectious diseases;
- Urinary tract infections/kidney infections;
- Cardiac defibrillation;
- Seizures; and
- Dorsal/lumbar fusions.

Potentially Preventable Hospital Readmissions

Potentially preventable hospital readmissions are when a patient is readmitted to an acute care hospital for a reason that is clinically related to the initial hospitalization or from deficiencies in a post-hospital discharge follow-up after a prior acute care admission[288] within thirty days of a hospital discharge.[289]

Throughout FFY 2019-2020, 30,593 PPEs were identified with at least one potentially preventable hospital readmission, compared to 31,689 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[290]

- Schizophrenia;
- Bipolar disorders;
- Major depression;
- Septicemia;
- Heart failure;
- Sickle cell crises;
- Chronic obstructive pulmonary disease;

[285] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[286] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[287] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Hospital Admissions (PPAs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPAsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[288] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[289] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[290] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Readmissions (PPRs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPRsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).

- Diabetes;
- Cesarean deliveries; and
- Child behavior disorders.

Effect of the bill - Potentially Preventable Health Care Events (PPEs)

The bill amends s. 409.967, F.S., to require the AHCA to produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees" annually. The report must include an analysis of the potentially preventable hospital emergency department visits, admissions, and readmissions that occurred during the previous state fiscal year, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each PPE or category of PPEs.

The bill authorizes the AHCA to include any other data or analysis parameters necessary to augment the report, and requires trend demonstrations be included in the report using historical data and requires the AHCA to submit this report annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The bill authorizes the AHCA to contract with a third-party vendor to produce the report.

Acute Hospital Care at Home (AHCAH) Initiative

Hospitals are licensed and regulated pursuant to ch. 395, F.S., by the Agency for Health Care Administration (AHCA). In addition, the federal Centers for Medicare and Medicaid Services establish standards for hospitals to be eligible to treat (and receive payment for) Medicare patients, called Conditions of Participation.

In November, 2020, as part of the *Hospital Without Walls Initiative* to address the COVID-19 public health emergency and concerns about hospital bed capacity, the federal Centers for Medicare and Medicaid Services (CMS) began issuing waivers to eligible hospitals authorizing the practice of acute hospital care at home under the Acute Hospital Care at Home Program (Program).[291] Specifically, CMS waived s. 482.23(b) and (b)(1) of the Medicare Hospital Conditions of Participation, in effect suspending the requirement for nursing services to be provided on premises 24 hours a day, seven days a week, and for the immediate availability of a registered nurse. In December, 2022, CMS extended the program from the first day after the end of the national public health emergency until December 31, 2024.[292] There is speculation that the Program might become permanent.[293]

These authorizations effectively allow hospitals to provide an inpatient level of care to certain patients in their homes.[294] The Program treats patients who require acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring the patient's care needs on an ongoing basis.[295] Treatment for more than 60 acute conditions, such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease, may be provided through the Program.[296] Patient participation in the program is voluntary.[297]

To receive a waiver and participate in the Program, a hospital must:[298]

- Have appropriate screening protocols in place before care at home begins to assess both medical and non-medical factors;

[291] Centers for Medicare and Medicaid Services, Press Release – CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge, https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge (last visited January 22, 2024).
[292] 42 U.S.C. §1395cc-7 (2022).
[293] Bill Siwicki, Healthcare IT News, *Will CMS' Acute Hospital Care at Home Waiver Program Become Permanent?* (August 28, 2023), available at https://www.healthcareitnews.com/news/will-cms-acute-hospital-care-home-waiver-program-become-permanent#:~:text=Even%20with%20the%20public%20health,including%20hospital%2Dat%2Dhome (last visited January 22, 2024).
[294] A patient's home is his or her permanent residence, which includes assisted living, but does not include nursing homes.
[295] *Supra*, note **Error! Bookmark not defined.**.
[296] *Id.*
[297] Centers for Medicare and Medicaid Services, *Acute Hospital Care at Home Frequently Asked Questions,* https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2 (last visited January 22, 2024).
[298] Centers for Medicare and Medicaid Services, Acute Hospital Care at Home Program Approved List of Hospitals as of 4/5/2021, available at https://www.cms.gov/files/document/covid-acute-hospital-care-home-program-approved-list-hospitals.pdf (last visited January 22, 2024).

- Have a physician or advanced practice provider evaluate each patient daily either in-person or remotely;
- Have a registered nurse evaluate each patient once daily either in-person or remotely;
- Have two in-person visits daily by either registered nurses or mobile integrated health paramedics based on the patient's nursing plan and hospital policies;
- Have the capability of immediate, on-demand remote audio connection with an Acute Hospital Care at Home team member who can immediately connect either an RN or MD to the patient;
- Have the ability to respond to a decompensating patient within 30 minutes;
- Track several patient safety metrics with weekly or monthly reporting, depending on the
- hospital's prior experience level;
- Establish a local safety committee to review patient safety data;
- Use an accepted patient leveling process to ensure that only patients requiring an acute level of care are treated; and
- Providing or contracting for other services required during an inpatient hospitalization.

Programs must obtain a waiver from AHCA rule requiring only registered nurses to conduct evaluations in order for paramedics to conduct such in-person visits.[299] As of December 14, 2023, 308 hospitals in 37 states have Acute Hospital Care at Home Programs. There are 12 hospitals in Florida approved to participate in the Program, including:[300]

- Mayo Clinic Florida;
- Cleveland Clinic Hospital;
- Cleveland Clinic Martin North;
- Cleveland Clinic Indian River;
- Palm Bay Hospital;
- Holmes Regional Medical Center;
- Viera Hospital;
- Cape Canaveral Hospital;
- Keralty Hospital;
- Tampa General Hospital;
- Orlando Regional Medical Center; and
- AdventHealth Orlando.

Effect of the bill - Acute Hospital Care at Home (AHCAH) Initiative

The bill requires AHCA to seek the federal approval necessary to implement an Acute Hospital Care at Home Program under the state Medicaid program, and requires the Program to be substantially consistent with the temporary Program currently authorized by CMS.

Inherent within the foundation of these programs, is that the primary payors for services are Medicare and Private Insurance. The Medicaid population that would be eligible for services under an Acute Hospital Care at Home Program is unknown, but is likely minimal.

Access to Health Care Act

Section 766.1115, F.S., creates the "Access to Health Care Act" to provide protections against liability for health care providers who offer free quality medical services to underserved populations in Florida. The act provides that a health care provider that executes a contract with a governmental contractor[301] to provide health care services is considered an agent of the state for sovereign immunity purposes when acting under the scope of duties under the contract and may not be named as a defendant in any action arising out of medical care or treatment provided under the contracts entered into.

[299] Programs must obtain an AHCA waiver for Rule 59A-3.243(4)(c) and (6), F.A.C., relating to nursing services.
[300] *Id.*
[301] The Access to Health Care Act defines "governmental contractor" as DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity. s. 766.1115(3)(c), F.S.

For the purposes of the Access to Health Care Act, a health care provider includes:

- A birth center.
- An ambulatory surgical center.
- A hospital.
- A medical doctor, osteopathic physician, or PA.
- A chiropractic physician.
- A podiatric physician.
- A registered nurse, nurse midwife, licensed practical nurse (LPN), or APRN or any facility which employs nurses to supply all or part of the care delivered.
- A midwife.
- A health maintenance organization.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A dentist or dental hygienist.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the listed professionals.

Volunteer Health Care Provider Program

Through the Access to Health Care Act, DOH established the Volunteer Health Care Provider Program (Program). The Program improves access to free medical and dental services for uninsured and underserved low-income residents.[302] For the purposes of the Act, low-income means:[303]

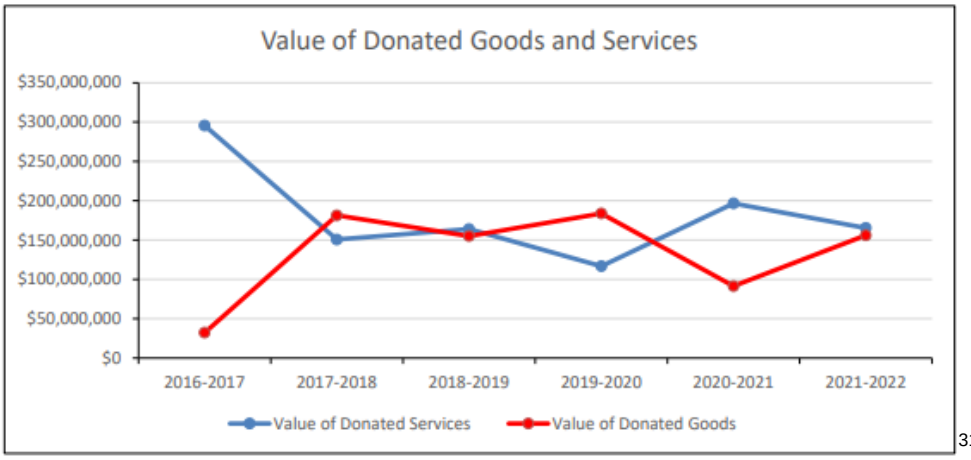
- A person who is Medicaid-eligible under Florida law;
- A person without health insurance and whose family income does not exceed 200 percent of the federal poverty level (FPL) as defined annually be the federal Office of Management and Budget; or
- Any client of DOH who voluntarily chooses to participate in a DOH-offered or DOH-approved program and who meets program eligibility requirements.

The governmental contractor or health care provider will determine and approve client eligibility based on these three eligibility groups.[304] The Program trains non-licensed volunteers to determine eligibility and refer individuals to providers for primary or specialty care. According to DOH's annual report for FY 21-22, DOH maintained 1,382 eligibility and referral specialists.[305] In addition, any federally funded community health center and any volunteer corporation or volunteer health care provider that delivers health care services are also included.[306] The health care providers participating in the Program primarily are community and faith-based medical clinics.[307] In FY 21-22, DOH reports a total of 219 community and faith-based clinics and organizations with 10,043 licensed health care professionals.[308]

Since the inception of the Volunteer Health Care Provider Program (Program) in 1992, DOH documented more than $4.9 billion in donated goods and services.[309] For FY 21-22, DOH reports the value of health-related goods and services totaled more than $321 million.[310] As illustrated in the graph

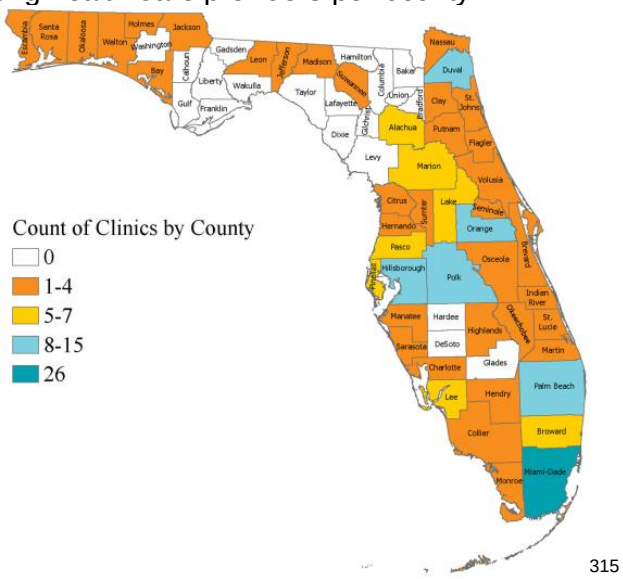
[302] Florida Dept. of Health, *Volunteer Heath Care Provider Program Annual Report Fiscal Year 2021-22*, p. 2 (Dec. 2022) https://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/vhs2122annualreport.pdf (last visited January 22, 2024).
[303] Section 766.1115(3)(e), F.S.
[304] R. 64I-2.002(1), F.A.C.
[305] *Id.* at 1.
[306] Section 766.1115(3)(d), F.S.
[307] *Supra*, FN 2 at 2.
[308] *Id.* at 1.
[309] *Id.*
[310] *Id.*

below, the value of 872,653 donated hours amongst all clinics and organizations is $165 million, and the value of the donations of money, supplies, and equipment received by 140 clinics and organizations is $156 million.[311]



[312]

During FY 21-22, an aggregate total of 443,971 health care services were provided to eligible individuals.[313] The number of counties with participating clinics and organizations increased from 44 to 47.[314] The county-by-county map below depicts which counties the Program served during FY 21-22 and the number of participating health care providers per county.



[315]

Sovereign Immunity

Sovereign immunity means a government is immune from being sued in its own courts without its consent.[316] The Florida Constitution grants absolute sovereign immunity to the state and its agencies.[317] At its discretion, Florida may waive sovereign immunity for any cause of action by legislative enactment or constitutional amendment.[318]

Florida waived sovereign immunity in tort actions.[319] Specifically, a tort action against the state for damages is available to remedy injury or loss of property, personal injury, or death caused by the

[311] *Id.* at 8.
[312] *Id.*
[313] *Id.* at 1.
[314] *Id.* at 4. DOH intends to increase Program service to 55 counties by December 30, 2025. Eight clinics closed in FY 21-22 and did not provide any volunteer services.
[315] *Id.* at 5.
[316] Bryan Garner, *Immunity (1) – Sovereign Immunity (1)*, Black's Law Dictionary, 11th ed. 2019, Accessed Westlaw Dec. 16, 2023.
[317] *Circuit Court of Twelfth Judicial Circuit v. Dep't of Nat'l Resources*, 339 So.2d 1113, 1114 (Fla. 1976); "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." Art. X, s. 13, *Fla. Const*.
[318] *Circuit Court of Twelfth Judicial Circuit*, 339 So.2d at 1114.
[319] s. 768.28(1), F.S.

negligent or wrongful act or omission of any state government personnel while acting within the scope of their employment.[320] A state government "officer, employee, or agent" includes any health care provider when providing services under the Access to Health Care Act.[321]

The state currently caps damages in suits against the state at $200,000 per person and $300,000 per incident.[322] MQA reports zero claims filed against the Program since March 2012.

Effect of the bill - Access to Health Care Act

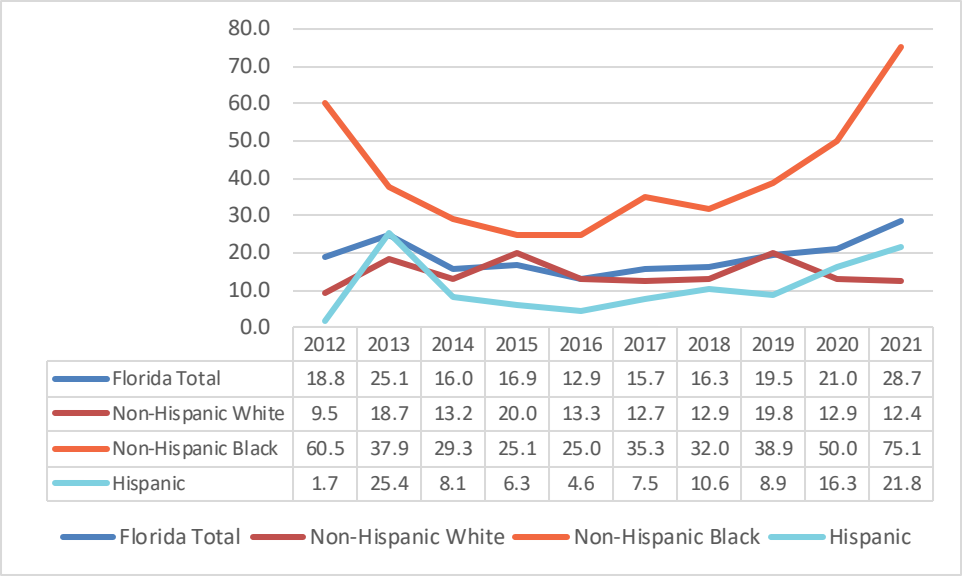
The bill increases the maximum family income allowable under the Program to receive free medical and dental services for uninsured and underserved low-income residents from those whose family income does not exceed 200% of the federal poverty level to those whose family income does not exceed 300% of the federal poverty level. This change will increase the number of people eligible for services under the Program while allowing the providers to retain sovereign immunity protections.

Telehealth Minority Maternity Care Pilot Program

Maternal Mortality and Morbidity

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[323] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019.[324] The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.[325] Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[326] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[327]

[320] *Id*.
[321] Sections 768.28(9)(2); 766.1115(4), F.S.
[322] Section 768.28(5)(a), F.S. For a plaintiff to overcome the cap on damages, the Legislature may enact a claims bill to cover the balance of a judgment in excess of the cap or the state agency can settle a judgment rendered against within the limits of the agency's insurance coverage.
[323] U.S. Dep't of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health*, (Dec. 2020), available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (Last visited January 22, 2024).
[324] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021,* (March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited January 22, 2024).
[325] *Id.*
[326] *Id*.
[327] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic*, (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (Last visited January 22, 2024).



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Florida Total	18.8	25.1	16.0	16.9	12.9	15.7	16.3	19.5	21.0	28.7
Non-Hispanic White	9.5	18.7	13.2	20.0	13.3	12.7	12.9	19.8	12.9	12.4
Non-Hispanic Black	60.5	37.9	29.3	25.1	25.0	35.3	32.0	38.9	50.0	75.1
Hispanic	1.7	25.4	8.1	6.3	4.6	7.5	10.6	8.9	16.3	21.8

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[328] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida as evidenced in the following chart:

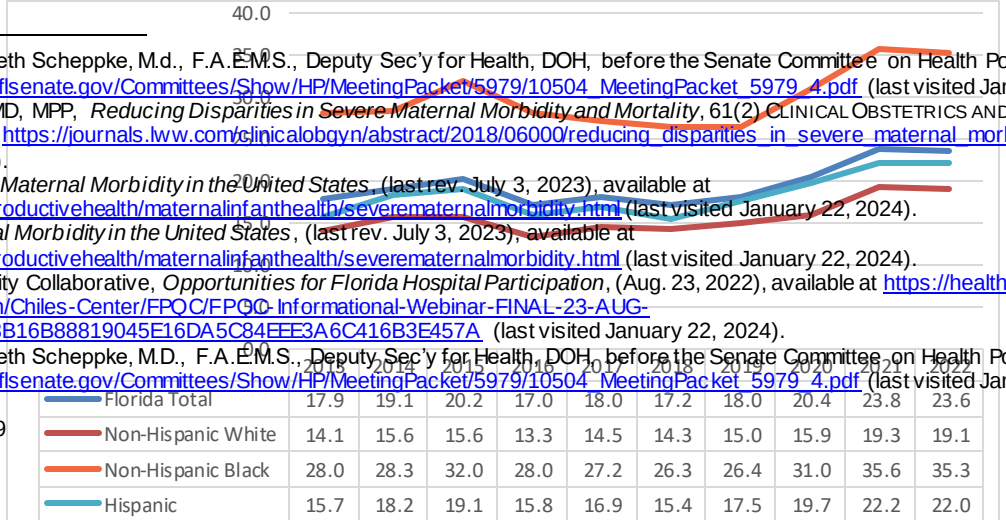
Severe Maternal Morbidity

For every maternal death, 100 women suffer a severe obstetric morbidity, a life-threatening diagnosis, or undergo a lifesaving procedure during their delivery hospitalization.[329] Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years.[330]

The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.[331] The leading causes of SMM in 2021 were:

- Blood transfusion;
- Disseminated intravascular coagulation;
- Acute renal failure;
- Sepsis;
- Adult respiratory distress syndrome;
- Hysterectomy;
- Shock;
- Ventilation; and
- Eclampsia.[332]

From 2013 to 2022, there were 51,454 cases of SMM among delivery hospitalization in Florida.[333] The following figure shows the trend over time for SMM rates in Florida per 1,000 delivery hospitalizations:[334]



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Florida Total	17.9	19.1	20.2	17.0	18.0	17.2	18.0	20.4	23.8	23.6	
Non-Hispanic White	14.1	15.6	15.6	13.3	14.5	14.3	15.0	15.9	19.3	19.1	
Non-Hispanic Black	28.0	28.3	32.0	28.0	27.2	26.3	26.4	31.0	35.6	35.3	
Hispanic	15.7	18.2	19.1	15.8	16.9	15.4	17.5	19.7	22.2	22.0	

[328] Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 22, 2024).
[329] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 22, 2024).
[330] *Id.*, and CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 22, 2024).
[331] CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 22, 2024).
[332] Florida Perinatal Quality Collaborative, *Opportunities for Florida Hospital Participation*, (Aug. 23, 2022), available at https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/FPQC-Informational-Webinar-FINAL-23-AUG-22.ashx?la=en&hash=93B16B88819045E16DA5C84EEE3A6C416B3E457A (last visited January 22, 2024).
[333] Presentation by Kenneth Scheppke, M.D., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 22, 2024).
[334] *Id.*

Similar to maternal mortality rates, rates of SMM are higher in racial and ethnic minority women.[335]

Telehealth Minority Maternity Care Pilot Program

In 2021, the Legislature created the Telehealth Minority Maternity Care Pilot Program in Duval and Orange counties to increase positive maternal health outcomes in racial and ethnic minority populations.[336]

DOH received funding in the 2023-2024 FY[337] to expand the pilot program to an additional 18 counties.[338] The additional counties are Brevard, Broward, Collier, Escambia, Hillsborough, Lake, Lee, Leon, Manatee, Marion, Miami-Dade, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and Volusia.

The pilot programs use telehealth to coordinate with prenatal home visiting programs to provide the following services and education to eligible pregnant women[339] up to the last day of their postpartum period:

- Referrals to Healthy Start's[340] coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;[341]
- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices for prenatal women to conduct key components of maternal wellness checks.[342]

The pilot programs also provide training to participating health care practitioners on:

- Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers;
- The use of remote patient monitoring tools;
- How to screen for social determinants of health risks in prenatal and postpartum periods;
- Best practices to screen for, evaluate, and treat mental health conditions and substance use disorders, as needed; and
- Collection of information, recording, and evaluation activities for program and patient evaluations.[343]

According to DOH, since the program's implementation, it has served more than 2,500 women in Duval and Orange counties, and 95 percent of the participants have reported that the program addressed an

[335] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 22, 2024).
[336] Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.
[337] Chapter 2023-239, Laws of Florida, line item 435.
[338] Florida Department of Health, Office of Minority Health, *Request for Applications: Programs to Reduce Severe Maternal Morbidity through Telehealth (SMMT) in Florida, RFA #22-002*, (April 19, 2023), available at https://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA22-002.pdf#Open%20in%20new%20window (last visited January 22, 2024).
[339] An "eligible pregnant woman" is a pregnant woman who is receiving, or is eligible to receive, maternal or infant services from the DOH under ch. 381, F.S. or ch. 383, F.S.
[340] Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risks factors associated with preterm birth, low birth weight, infant mortality, and poor development outcomes. *See* DOH, *Healthy Start*, available at https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited January 22, 2024).
[341] Social determinants of health refer to the conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environments, and social and community context. *See* U.S. Dep't of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited January 22, 2024).
[342] Section 383.2163(3), F.S.
[343] Section 383.2163(4), F.S.

unmet social need.[344] The five most prevalent critical factors were food scarcity, childcare, paid work opportunities, affordability and access to utilities such as the Internet, and access to stable housing.

Additionally, 71 percent of the enrolled women in Duval County and 85 percent of enrolled women in Orange County reported high satisfaction with the implementation of the technology in the pilot program.[345] The enrolled women were provided blood pressure cuffs, scales, and glucose monitors to remotely screen and treat common pregnancy-related complications.

Effect of the bill - Telehealth Minority Maternity Care Pilot Program

The bill expands the current Telehealth Minority Maternity Care pilot program into a statewide program and, beginning October 31, 2025, requires the DOH to annually report on the program to the Governor and the Legislature. The annual report, which is due each October 31, must include, at a minimum, all of the following from the previous fiscal year:

- The total number of clients served and demographic information for the population served, including ethnicity and race, age, education levels, and geographic location;
- The total number of screenings performed, by type;
- The number of participants identified as having experienced pregnancy-related complications, the number who received treatments for such complications, and the final outcome of the pregnancy for such participants;
- The number of referrals made to Healthy Start and other prenatal home visiting programs and the number of participants who ultimately received services from such programs;
- The number of referrals made to doulas and other perinatal professionals and the number of participants who subsequently received such services;
- The number and types of devices provided to participants to conduct wellness checks;
- The average length of participation by program participants;
- Composite results of a participant survey that measures the participants' experience with the program;
- The total number of health care practitioners trained by provider type and specialty;
- The results of a survey of health care practitioners trained under the program. The survey must address the quality and impact of the training provided, the healthcare practitioners experiences using remote patient monitoring tools, the best practices provided in the training, and any suggestions for improvement;
- Aggregate data on the maternal and infant health outcomes of program participants; and
- For the initial report, all available quantifiable data related to the pilot program.

The bill appropriates $23,357,876in recurring funds from the General Revenue Fund to the Grants and Aids – Minority Health Initiative Category, to the DOH to expand the telehealth minority maternity care program statewide.

Health Care Screening

The Florida Statutes contain numerous health screening programs, such as:

Section Number	Type of Screening	Text or Summary	Agency in Charge
381.815	Sickle-Cell disease	"Work cooperatively with not-for-profit centers to provide community-based education, patient teaching, and counseling and to encourage diagnostic screening."	DOH
381.0038	Requires needle exchange programs to provide HIV and hepatitis screenings, or referrals. Not state operated or	"An exchange program must: Provide onsite counseling or referrals for drug abuse prevention, education, and treatment, and provide onsite HIV and viral hepatitis screening or referrals for such screening. If such services are offered solely by referral, they must be made available to participants within 72 hours."	DOH, however exchange programs are not state operated or funded.

[344] Email correspondence the DOH dated October 30, 2023 (on file with the Senate Committee on Health Policy).
[345] *Id.*

	funded.		
381.004	HIV Testing	Requires the DOH to run HIV screening programs in each county.	DOH
381.0056	School Health Screenings	Includes vision, hearing, scoliosis, growth and development, health counseling, referrals for suspected or confirmed health problems, and preventative dental program.	County Health Departments in conjunction with District School Boards
381.91	Cancer Screenings	Community faith-based disease-prevention program to offer cancer screening, diagnosis, education, and treatment services to low-income populations throughout the state.	DOH operated from community health centers within the Health Choice Network
381.93	Breast and Cervical Cancer	"Mary Brogan Breast and Cervical Cancer Early Detection Program." The Department of Health, using available federal funds and state funds appropriated for that purpose, is authorized to establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program to provide screening, diagnosis, evaluation, treatment, case management, and follow-up and referral to the Agency for Health Care Administration for coverage of treatment services.	DOH
381.932	Breast Cancer	"Breast cancer early detection and treatment referral program." The purposes of the program are to: (a) Promote referrals for the screening, detection, and treatment of breast cancer among unserved or underserved populations. (b) Educate the public regarding breast cancer and the benefits of early detection. (c) Provide referral services for persons seeking treatment. "Underserved Population" defined as: 1. At or below 200 percent of the federal poverty level for individuals; 2. Without health insurance that covers breast cancer screenings; and 3. Nineteen to 64 years of age, inclusive.	DOH
381.96	Wellness Screenings for women	"Wellness services" means services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to, high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation.	Pregnancy Care Network (Contracted by DOH).
381.985	Lead Poisoning	Lead poisoning screenings for children at risk for exposure to lead.	DOH
383.011, 383.14-383.147	Newborn Screenings	Various required test for newborns and infants.	DOH
385.103	Cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease.	Chronic Disease Intervention Programs The department shall assist the county health departments in developing and operating community intervention programs throughout the state. At a minimum, the community intervention programs shall address one to three of the following chronic diseases: cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease. Uses community funding, gifts, grans, and other funding. Requires volunteers to be used to the maximum extent possible.	DOH
385.206	Hematology-Oncology Sickle-cell anemia	Allows DOH to make grants and reimbursements to designated centers to establish and maintain programs for the care of patients with hematologic and oncologic disorders. Requires such programs to offer screenings and counseling for patients with sickle-cell anemia or other hemoglobinopathies.	DOH, through grants
392.61	Tuberculosis	DOH is required to operate TB control programs in each state including community and individual screenings	DOH

Effect of the bill - Health Care Screening

The bill creates s. 381.9855, F.S., to require the DOH to implement a Health Care Screening and Services Grant Program (HCSSGP). The purpose of the HCSSGP is to fund the provisions of no-cost health care screenings or services for the general public by nonprofit entities. The bill requires the DOH to:

- Publicize the availability of funds and enlist the aid of county health departments for outreach to potential applicants at the local level.
- Establish an application process for submitting a grant proposal and criteria an applicant must meet to be eligible.
- Develop guidelines a grant recipient must follow for expenditure of grant funds and uniform data reporting requirements for the purpose of evaluating the performance of grant recipients.

A nonprofit entity may apply for grant funding to implement new health care screening or services programs or to provide the same or similar screenings that it is currently providing in new locations or through a mobile health clinic or mobile unit in order to expand the program's delivery capabilities. Entities that receive funding under the HCSSGP are required to:

- Follow DOH guidelines for reporting on expenditure of grant funds and measures to evaluate the effectiveness of the entity's health care screening or services program; and
- Publicize to the general public and encourage the use of the health care screening portal created by the section.

The bill requires the DOH to create and maintain an Internet-based portal, with a clear and conspicuous link on the home page of its website, to direct the general public to events, organizations, and venues from which health care screenings or services may be obtained at no cost or at a reduced cost and to direct licensed health care practitioners to opportunities to volunteer their services for such screenings and services. The bill authorizes the DOH to contract with a third-party vendor for the portal.

The portal must be easily accessible by the public, not require a sign-up or login, and include the ability for a member of the public to enter his or her address and obtain localized and current data on opportunities for screenings and services and volunteer opportunities for health care practitioners. The portal is required to include all statutorily created screening programs that are funded and operational under the DOH's authority. The DOH is required to coordinate with county health departments (CHD) to include screenings and services provided by the CHDs or by nonprofit entities in partnership with the CHDs.

Florida Center for Nursing

Current Situation

In 2001, the Florida Legislature created s. 464.0195, F.S., establishing the Florida Center for Nursing "to address issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse workforce resources." The primary statutory goals address collecting and analyzing nursing workforce data; developing and disseminating a strategic plan for nursing; developing and implementing reward and recognition activities for nurses; and promoting nursing excellence programs, image building, and recruiting into the profession.

The Florida Center for Nursing conducts an analysis of licensed practical nurses, registered nurses, and advanced practice registered nurses annually to assess Florida's nurse supply, including the numbers of nurses, demographics, education, employment status, and specialization pursuant to s. 467.019, F.S. The Florida Center for Nursing is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 30 each year through January 30, 2025.

Effect of the bill – Florida Center for Nursing

The current requirement for the Florida Center for Nursing to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, will sunset after the report that is due on January 30, 2025. The bill deletes that sunset date, providing that the report will be due each January 30 in perpetuity.

Linking Industry to Nursing Education

Established by the Legislature in 2022, the Linking Industry to Nursing Education (LINE) fund is a competitive grant program intended to address critical nursing workforce needs by incentivizing collaboration between nursing education programs and healthcare partners.[346] The LINE fund provides matching funds on a dollar-to-dollar basis, subject to funds availability, to participating institutions that partner with a healthcare provider to meet local, regional, and state workforce needs.[347] LINE funds may be used for resident student scholarships, recruitment of additional faculty, equipment, and simulation centers to advance high-quality nursing education programs throughout the state.[348] LINE funds may not be used for the construction of new buildings.[349]

In order to be eligible to receive LINE funds, an institution[350] must have a nursing education program that meets certain, specified criteria. Among the criteria is a minimum program completion rate or first-time passage rate on the National Council of State Boards of Nursing Licensing Examination (NCLEX). Specifically, the institution must have a nursing education program that meets or exceeds the following[351]:

- For a certified nursing assistant program, a completion rate of at least 70 percent for the prior year.
- For a licensed practical nurse, associate of science in nursing and bachelor of science in nursing program, a first-time passage rate on the National Council of State Boards of Nursing Licensing Examination of at least 70 percent for the prior year.

The LINE fund is administered by the Board of Governors (BOG) for State University System (SUS) institutions and the Department of Education (DOE) for all other institutions. Per DOE, non-SUS institutions with more than one nursing education program must demonstrate that at least one active program meets or exceeds the completion or passage rate criterion.[352] Additionally, school districts with more than one career center are not required to meet performance metrics for all operating career centers; however, LINE funds may only be expended at the career centers that meet or exceed the completion or passage rate criterion.[353] Additionally, per DOE guidance applicable to non-SUS institutions, new nursing education programs may not be used to determine eligibility.[354]

An institution that wishes to receive LINE funds must submit a timely and complete proposal to the BOG or DOE, as applicable.[355] The proposal must identify a healthcare partner[356] located and licensed to operate in the state whose monetary contributions will be matched on a dollar-to-dollar basis.[357]

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[346] Section 1009.8962, F.S.
[347] Section 1009.8962(5), F.S.
[348] Section 1009.8962(6)(a), F.S.
[349] Section 1009.8962(6)(b), F.S.
[350] For purposes of the LINE program, 'institution' means a school district career center under s. 1001.44, a charter technical career center under s. 1002.34, a Florida College System institution, a state university, or an independent nonprofit college or university located and chartered in this state and accredited by an agency or association that is recognized by the database created and maintained by the United States Department of Education to grant baccalaureate degrees, which has a nursing education program that meets or exceeds certain, specified completion rates or licensure passage rates. *See* s. 1009.8962(3)(b), F.S.
[351] Section 1009.8962(3)(b), F.S.
[352] *See* Florida Department of Education 'Notice of Intent-To-Apply Form, Linking Industry to Nursing Education (LINE)' here. (Last visited January 22, 2024).
[353] *Id.*
[354] *See* 'Linking Industry to Nursing Education (LINE) Fund Frequently Asked Questions,' question #28, here. (Last visited January 22, 2024).
[355] Section 1009.8962(7)(a), F.S.
[356] For purposes of the LINE program, a 'healthcare partner' is defined a provider as defined in s. 408.803, F.S.; a clinical laboratory providing services in this state or services to health care providers in this state, if the clinical laboratory is certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; federally qualified health center as defined in 42 U.S.C. s. 1396d(l)(2)(B), as that definition existed on March 29, 2021; any site providing health care services which was established for the purpose of responding to the COVID-19 pandemic pursuant to any federal or state order, declaration, or waiver; a health care practitioner as defined in s. 456.001; a health care professional licensed under part IV of chapter 468; a home health aide as defined in s. 400.462(15); a provider licensed under chapter 394

The BOG or DOE, as applicable, must review and evaluate each completed and timely proposal according to the following minimum criteria[358]:

- Whether funds committed by the health care partner will contribute to an eligible purpose.
- How the institution plans to use the funds, including how such funds will be utilized to increase student enrollment and program completion.
- How the health care partner will onboard and retain graduates.
- How the funds will expand the institution's nursing education programs to meet local, regional, or state workforce demands. If applicable, this shall include advanced education nursing programs and how the funds will increase the number of faculty and clinical preceptors and planned efforts to utilize the clinical placement process.

Per BOG regulation, additional criteria for universities may be established by the SUS Chancellor as needed.[359] BOG regulation also states the BOG will award funding based on the merit of each proposal, funds may be awarded on a first-come, first-served basis, and award amounts may be prorated depending on the number of approved proposals and the dollar amounts requested.[360] Per State Board of Education rule, the DOE, for all non-SUS proposals, will also consider the strength of the proposed programs, the geographic location of the proposals and statewide workforce demands in order to promote the distribution of funds and avoid a concentration of funds in a small number of institutions.[361]

Each institution with an approved proposal is required to notify the BOG or DOE, as applicable, upon receipt of the funds from the healthcare partner identified in the proposal. Once notified, the BOG or DOE, as applicable is required to release the LINE funds, on a dollar-to-dollar basis, up to the amount of funds received by the institution.

Annually, by February 1, each institution awarded LINE funds in the previous fiscal year is required to submit a report to the BOG or DOE, as applicable, that demonstrates the expansion as outlined in the proposal and the use of the funds. At minimum, the report must include, by program level, the number of additional nursing education students enrolled; if scholarships were awarded using grant funds, the number of students who received scholarships and the average award amount; as well as student outcomes.

For Fiscal Years 2022-2023 and 2023-2024, the Florida Legislature allocated $6 million in LINE funding each year to the State University System.[362] For Fiscal Year 2022-2023, the BOG approved proposals from eight state universities across two application submission periods.[363] For Fiscal Year 2023-2024, proposals submitted by nine state universities were approved as of December 2023.[364] The requested funds for these proposals were primarily intended to fund student scholarships, simulation centers, and faculty salaries.[365]

For Fiscal Years 2022-2023 and 2023-2024, the Florida Legislature allocated $19 million in LINE funding each year to the Department of Education to fund proposals from Florida's public-school districts (career centers), Florida College System institutions, and independent nonprofit colleges and universities. For Fiscal Year 2022-2023, proposals submitted by 26 school districts and institutions were approved.[366]

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or chapter 397 and its clinical and nonclinical staff providing inpatient or outpatient services; a continuing care facility licensed under chapter 651; a pharmacy permitted under chapter 465. *See* s. 768.38(2), F.S.

[357] Section 1009.8962(7)(b), F.S.

[358] Section 1009.8962(8), F.S.

[359] BOG Regulation 8.008(1)(d)2.

[360] *Id.*

[361] Rule 6A-10.0352(5)(b), F.A.C.

[362] Specific Appropriation 143A, Ch. 2022-156, L.O.F. and Specific Appropriation 142, Ch. 2023-239, L.O.F.

[363] *See* State University System of Florida Board of Governors meeting documents for September 14, 2022, here and November 9, 2022, here. (last viewed January 22, 2024). (Last visited January 22, 2024).

[364] *See* State University System of Florida Board of Governors meeting documents for September 8, 2023, here and November 9, 2023, here. (last viewed January 22, 2024). (Last visited January 22, 2024).

[365] *See* State University System of Florida Board of Governors meeting presentations for September 13, 2022, here, November 9, 2022, here, September 8, 2023, here, and November 9, 2023, here.

[366] *See* '2022-2023 LINE Fund Prioritized Funding List,' here. (Last visited January 22, 2024).

Florida's public career centers, state colleges, state universities, and independent nonprofit colleges and universities that meet the minimum completion or passage rates have been eligible since the LINE Fund's inception. The 2023-2024 General Appropriations Act appropriated $5 million in nonrecurring funds to accredited private educational institutions that meet the same criteria as the public career centers, state colleges, state universities, and other private colleges and universities that are eligible for the LINE program.[367]

Effect of the bill - Linking Industry to Nursing Education

The bill expands the statutory LINE Fund program to include independent schools, colleges, or universities with an accredited nursing program that is located in and chartered by Florida and is licensed by the Commission for Independent Education. Pursuant to the bill, 'accredited program' means a program for the prelicensure education of professional or practical nurses that is conducted in the United States at an educational institution, whether in this state, another state, or the District of Columbia, and that is accredited by a specialized nursing accrediting agency that is nationally recognized by the United States Secretary of Education to accredit nursing education programs.

The also bill increases the passage rate for the NCLEX, from 70 percent to 75 percent, that is required for LPN, associate of science in nursing, and bachelor of science in nursing programs in order to be eligible to participate in the program and receive LINE funds. Additionally, the bill requires the passage rate be based on a minimum of 10 testing participants.

Developmental Research Laboratory Schools

Developmental research laboratory schools (lab schools) are an established category of public schools that provide sequential instruction and are affiliated with a college of education within the state university of closet geographic proximity.[368] Lab schools are required to establish admission processes that are designed to result in a representative sample of the public school enrollment based on gender, race, socioeconomic status, and academic ability.[369] As part of a lab school's mission, there must be an emphasis on mathematics, science, computer science, and foreign languages.[370] Additionally, as part of the lab school's primary goal, the school is required to enhance instruction and research in such specialized subjects by using the resources available on the university's campus. Currently, there are four universities that have lab schools:[371]

- Florida Atlantic University
- Florida State University
- Florida Agricultural and Mechanical University
- University of Florida

A university is limited to one lab school, except for a charter lab school or one that serves military families near a military installation.[372] State universities operate four charter lab schools, which are Florida State University Charter Lab K-12 School in Broward County, Florida Atlantic University Charter Lab K-12 School in Palm Beach County, Florida Atlantic University Charter Lab K-12 School in St. Lucie County[373]and the Florida State University Collegiate School in Bay County.[374] In considering an application to establish a charter lab school, a state university must consult with the district school board of the county in which the school is located. If a state university denies or does not act on the application, the applicant may appeal such decision to the State Board of Education (SBE).[375]

[367] Specific Appropriation 58, Ch. 2023-239, L.O.F.
[368] Section 1002.32(2), F.S.
[369] Section 1002.32(4), F.S.
[370] Section 1002.34(3), F.S.
[371] Florida Department of Education, *Superintendents,* https://www.fldoe.org/accountability/data-sys/school-dis-data/superintendents.stml (last visited January 22, 2024)
[372] Section 1002.32(2), F.S.
[373] *Id.*
[374] Florida State University, The Collegiate School Panama City, https://tcs.fsu.edu/ (last visited January 22, 2024).
[375] Section 1002.33(6)(g), F.S.

Effect of the bill - Developmental Research Laboratory Schools

The bill requires each lab school to develop programs to accelerate the entry of enrolled students into articulated health care programs at its affiliated university or at any public or private postsecondary institution, with the approval of the university president. Additionally, a lab school must offer technical assistance to any Florida school district seeking to replicate the lab school's programs and must annually report, starting December 1, 2025, to the Legislature on the development of such programs and their results.

Advanced Birth Centers

Licensure

A birth center is any facility, institution, or place in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy, aside from an ambulatory surgical center, hospital, or part of a hospital.[376] Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA) under ch. 383. F.S., and part II of ch. 408, F.S. Birth centers must have a governing body responsible for the overall operation and maintenance of the birth center.[377] The governing body must develop and provide to all staff, clinicians, consultants, and licensing authorities, a manual that documents the policies, procedures, and protocols of the birth center.[378]

A birth center may accept only those patients who are expected to have normal pregnancies and deliveries. Prior to being accepted for care, the patient must sign an informed consent form.[379] A mother and her infant must be discharged from a birth center within 24 hours after giving birth, except when:[380]

- The mother is in a deep sleep at the end of the 24-hour period, in which case the mother must be discharged as soon after waking as feasible; or
- The 24-hour period is completed during the middle of the night.

If a mother or infant is retained at the birth center for more than 24 hours after birth, for any reason, the birth center must submit a report to AHCA within 48 hours of the birth describing the circumstances and the reasons for the decision.[381]

Staff

Birth centers are required to meet certain staffing requirements. Specifically, a birth center must:[382]

- Have at least one clinical staff[383] member for every two clients in labor;
- Have a clinical staff member or qualified personnel[384] available on-site during the entire time a client is in the birth center;
- Ensure that services during labor and delivery are provided by a physician, certified nurse midwife, or licensed midwife, assisted by at least one other staff member, under protocols developed by clinical staff; and
- Have qualified personnel or clinical staff who are able to perform neonatal resuscitation present during each birth.

Additionally, birth centers must ensure that all qualified personnel and clinical staff are trained in infant and adult resuscitation.[385]

Birth centers must have written consultation agreements with each consultant who has agreed to provide advice and services to the birth center.[386] A consultant must be a licensed medical doctor or

[376] Section 383.302(2), F.S.; Section 383.302(8), F.S. defines "low-risk pregnancy" as a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.
[377] Section 383.307, F.S.
[378] *Id.*
[379] Section 383.31, F.S. The informed consent form must advise the patient of the qualifications of the clinical staff, the risks related to out-of-hospital births, the benefits of out-of-hospital births, and the possibility of referral or transfer if complications arise during pregnancy or childbirth with additional costs for services rendered (Rule 59A-11.010, F.A.C.)
[380] Section 383.318(1), F.S., and Rule 59A-11.016(6), F.A.C.
[381] Section 383.318, F.S.
[382] Rule 59A-11.005(3), F.A.C.
[383] Section 383.302(3), F.S., defines "clinical staff" as individuals employed full-time or part-time by a birth center who are licensed or certified to provide care at childbirth.
[384] Rule 59A-11.002(6), F.A.C., defines "qualified staff" as an individual who is trained and competent in the services that he or she provides and is licensed or certified when required by statute or professional standard.
[385] Rule 59A-11.005(3), F.A.C.

licensed osteopathic physician who is either certified or eligible for certification by the American Board of Obstetrics and Gynecology, or has hospital obstetrical privileges.[387] Consultation may be provided onsite or by telephone.[388]

Clinical Records

Birth centers are required to maintain a complete clinical record for each client, which must include:[389]

- Identifying information including the client's name, address, and telephone number;
- Initial history and physical examination;
- Obstetrical risk assessments and pre-term labor risk assessments, including the dates of the assessments;
- The date and time of the onset of labor;
- The exact date and time of birth;
- All treatments rendered to the mother and newborn;
- The metabolic screening report;
- Condition of the mother and newborn, including any complications; and
- Referrals for medical care and transfers to hospitals.

Medical Treatments and Procedures

A birth center may perform simple laboratory tests and collect specimens for tests that are requested pursuant to its protocol.[390] A birth center is exempt from the clinical laboratory licensure requirements under ch. 483, F.S., if the birth center employs no more than five physicians and its testing is conducted exclusively in connection with the diagnosis and treatment of patients of the birth center.[391]
Birth centers may perform surgical procedures that are normally performed during uncomplicated childbirths, such as episiotomies and repairs. Birth centers may not perform operative obstetrics or caesarean sections.[392]

Birth centers may not administer general anesthesia or conduction anesthesia. Systemic analgesia and local anesthesia for pudendal block and episiotomy repair may be administered if procedures are outlined by the clinical staff and performed by personnel with statutory authority to do so.[393]
Birth centers may not inhibit, simulate, or augment labor with chemical agents during the first or second stage of labor unless prescribed by personnel with the statutory authority to do so and in connection with and prior to an emergency transport.[394]

Birth centers must provide postpartum care and evaluation that includes physical examination of the infant, metabolic screening tests, referral to pediatric care sources, maternal postpartum assessment, family planning, referral to secondary or tertiary care, and instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.[395]

Physical Plant

Birth centers must be designed to ensure adequate provision for birthing rooms, bath and toilet facilities, storage areas for supplies and equipment, examination areas, and reception or family areas.[396]
Birth centers are required to comply with the provisions of the Florida Building Code and Florida Fire Prevention Code applicable to birth centers.[397] The AHCA may enforce the special-occupancy

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[386] Section 383.315(1), F.S.
[387] Section 383.302(4), F.S.
[388] Section 383.315(2), F.S.
[389] Rule 59A-11.005(4), F.A.C.
[390] S. 383.313, F.S.
[391] *Id.*
[392] *Id.*
[393] *Id.*
[394] *Id.*
[395] Section 383.318, F.S.
[396] Section 383.308(1), F.S.
[397] Section 383.309(2), F.S.; Section 452 of the Florida Building Code provides requirements for birth centers.

provisions of the Florida Building Code and the Florida Fire Prevention Code that apply to birth centers when conducting inspections.[398]

Equipment

Birth centers must have the equipment necessary to provide low-risk maternity care and readily available equipment to initiate emergency procedures for mothers and infants during life-threatening events.[399] Such equipment must include:

- Oxygen with flow meter and mask or equivalent;
- Resuscitation equipment to include resuscitation bags and oral airways, and laryngoscopes and endotracheal tubes appropriate for the newborn;
- Emergency medications and intravenous fluids with supplies and equipment appropriate for administration;
- Sterile suturing equipment and supplies;
- An examining table and stool;
- An examination light;
- An adult beam scale;
- An infant scale;
- A sphygmomanometer and stethoscope;
- A clinical thermometer;
- A fetoscope or doppler unit;
- A bassinet;
- A sweep second hand clock;
- A mechanical suction or bulb suction; and
- A firm surface suitable for resuscitation.

Penalties and Fines

AHCA may impose an administrative fine not to exceed $500 per violation per day for the violation of any provision of the Birth Center Licensure Act, part II of chapter 408, or applicable rules.[400] AHCA may also impose an immediate moratorium on elective admissions to any birth center when it determines that any condition in the facility presents a threat to the public health or safety.[401]

Annual Report

Birth centers are required to submit an annual report to AHCA that details, among other things:[402]

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reasons for each transfer and whether it occurred intrapartum or postpartum, and the length of the subsequent hospital stay;
- Newborn transfers, including the reasons for each transfer, the birth weight, days in hospital, and Apgar score at five and ten minutes;[403]
- Newborn deaths;
- Stillborn/fetal deaths; and
- Maternal deaths.

[398] *Id.*
[399] Section 383.308(2)(a), F.S.
[400] S. 383.33, F.S.
[401] Id.
[402] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Feb. 2015).
[403] Apgar is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the health care provider how well the baby is doing outside the mother's womb. In rare cases, the test will be done 10 minutes after birth. See *Apgar Score*, Medline Plus, *available at* https://medlineplus.gov/ency/article/003402.htm (last visited January 22, 2024).

Effect of the bill - Advanced Birth Centers

Licensure

The bill creates a new designation for birth centers as advanced birth centers (ABCs), and allows ABCs to treat more types of patients and perform more types of procedures than traditional birth centers. The bill authorizes ABCs to perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the beginning of the 37th week of gestation through the end of the 41st week of gestation.

To be designated as an ABC, a birth center must maintain all the statutory requirements for both birth centers and advanced birth centers and:

- Meet all standards adopted by rule for birth centers, unless specified otherwise.
- Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.
- Be operated and staffed 24 hours per day, 7 days per week.
- Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified obstetrician and one of whom must be a board-certified anesthesiologist, both licensed under either ch. 458 or 459, F.S.
- Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.
- Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.
- Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions.
- Qualify for, enter into, and maintain a Medicaid provider agreement with AHCA pursuant to s. 409.907, F.S., and provide services to Medicaid recipients according to the terms of the provider agreement.

The bill requires AHCA to establish a procedure for designating birth centers as ABCs. Standards adopted for such designation must be, at a minimum, equivalent to the minimum standards for ASCs and include standards for quality of care, blood transfusions, and sanitary conditions for food handling and food service.

The bill creates s. 383.3131, F.S., to establish separate requirements for ABCs related to laboratory services, surgical services, administration of analgesia and anesthesia, and intrapartal use of chemical agents.

Medical Treatments and Procedures

ABCs must have an onsite clinical laboratory which is, at a minimum, capable of testing for hematology, metabolic screening, liver function, and coagulation studies. The ABC is authorized to collect specimens for those tests that are requested under protocol and may perform any tests authorized by AHCA in rule. Laboratories in ABCs must be appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

In addition to the surgical services a birth center may perform, the bill authorizes an ABC to perform surgical procedures for low-risk cesarean deliveries and surgical management of immediate complications. Additionally, an ABC may perform post-partum sterilization before the discharge of a patient who has given birth during her admission and may perform circumcisions before discharging newborn infants.

The bill authorizes an ABC to administer general, conduction, and local anesthesia if administered by personnel who have statutory authority to do so. All anesthesia must be administered by an anesthesiologist or certified registered nurse anesthetist (CRNA). If general anesthesia is administered,

a physician or CRNA must be present in the ABC during the anesthesia and the post anesthesia recovery period until the patient is fully alert.

The bill authorizes the use of chemical agents to inhibit, stimulate, or augment labor during the first or second stage of labor at an ABC if prescribed by personnel who have the statutory authority to do so. Labor may be induced at the 39th week of gestation for a patient with a document Bishop score of eight or greater.[404]

The bill requires ABCs to employ or maintain an agreement with an obstetrician who must be on call at all times during which a patient is in active labor in the center in order to attend deliveries, respond to emergencies, and, when necessary, perform cesarean deliveries. ABCs are also required to enter into a written transfer agreement with a local hospital for the transfer and admission of emergency patients or have a written agreement with an obstetrician who has hospital privileges and who has agreed to accept the transfer of the ABCs patients.

The bill allows an ABC to keep a mother and infant in the ABC for up to 48 hours after a vaginal delivery or up to 72 hours after a cesarean delivery, except in unusual circumstances as defined in rule by AHCA. If a mother or infant is retained longer than the allowed time, a report must be filed with AHCA within 48 hours of the scheduled discharge time which must describe the circumstances and reasons for keep the patient.

Health Care Spending

Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion.[405] Total national health expenditures grew by $175 billion in 2022 from 2021 with hospital expenditures and retail prescription drugs accounting for approximately one-third of the spending growth.[406]

Private insurance expenditures have also been growing at a faster pace than either Medicaid or Medicare spending. In 1970, private health insurance expenditures represented 20.4 percent of total health spending; whereas, for 2022, the percentage had grown to 28.9 percent.[407] Additionally, per enrollee spending by private insurers increased by 61.6 percent from 2008 to 2022, a rate that was faster than the per enrollee spending for public programs such as Medicare and Medicaid. From 2021 to 2022, the rate for private insurers was 4.3 percent while Medicaid rose by 2.2 percent and Medicare by 3.8 percent.[408]

The following chart illustrates the rate of growth in total national health expenditures from 1970 to 2022[409]:

[404] The Bishop scoring system is based on a digital cervical exam of a patient with a zero point minimum and 13 point maximum. The scoring system utilizes cervical dilation, position, effacement, consistency of the cervix, and fetal station. A Bishop score of 8 or greater is considered to be favorable for induction, or the chance of a vaginal delivery with induction is similar to spontaneous labor. A score of 6 or less is considered to be unfavorable if an induction is indicated cervical ripening agents may be utilized. See Wormer KC, Bauer A, Williford AE. Bishop Score. [Updated 2023 Sep 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available at https://www.ncbi.nlm.nih.gov/books/NBK470368/, (last visited January 22, 2024).

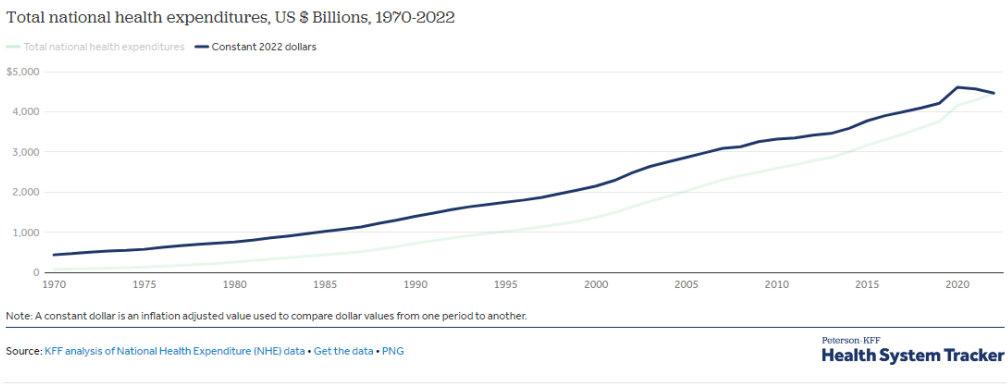
[405] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, December 15, 2023, available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2022 https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (last viewed on January 22, 2024).

[406] *Id.*

[407] *Id.*

[408] *Id.*

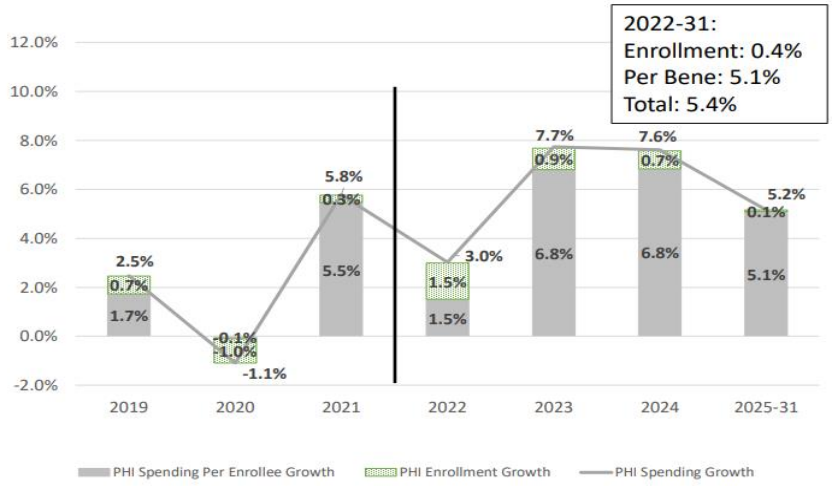
[409] *Supra*, note **Error! Bookmark not defined.**.



Health care prices are a primary driver of health care spending. While health care spending has slowed in recent decades, from a high of 12 percent in the 1970s to the current 9.6 percent for the 2020-2022 period, spending still consistently exceeds growth in the country's GDP.[410] Per enrollee spending for those with private health insurance in 2023 to 2024 is expected to be at a faster pace than in 2022 due to an increase in health care utilization and health care costs. Growth in the private health insurance market, according to the Chief Actuary's report,[411] is tied to increased enrollment in the Marketplace while additional subsidies were available under the American Rescue Plan Act.[412]

Projections for 2022-31 by the Office of the Actuary at Centers for Medicare and Medicaid Services show an average predicted growth rate in national health expenditures (NHE) of 5.4 percent which would outpace the expected average GDP growth rate for the same time period of 4.6 percent.[413] The chart below illustrates the average annual growth in enrollment per beneficiary spending, and total spending, by the designated time period.[414] The reductions shown for the outlier years of 2025 through 2031 are tied to the expiration of the Marketplace subsidies which exist in current law and the associated projected 10 percent or 2 million beneficiaries drop in privately purchased health insurance coverage.[415]

[410] *Supra*, note **Error! Bookmark not defined.**
[411] Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2022-31: Growth to Stabilize Once Public Health Emergency Ends*, June 14, 2023, Slide 10, available at *https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf* (Last visited January 22, 2024).
[412] *Id*. The American Rescue Plan Act of 2021 (P.L. 117-7) amended the Patient Protection and Affordable Care Ac (P.L. 111-148, March 28, 2010 and Health Care and Education Reconciliation Act of 2010 ((P.L. 2010 -152, March 30, 2010)), collectively know n as PPACA) to provide additional funding relief to the states to address a range of impacts from the COVID-19 pandemic. Included in its provisions, w as a special rule for any individual w ho had received or had been approved to receive unemployment compensation during 2021 for the plan year in w hich the compensation be gan w hich qualified any such individual for the same cost sharing subsidies for health care expenses under qualified health insurance plans in the Marketp lace as any other individual in a household income of 133 percent of the poverty or less for the family size involved. The special rule w as effective with plan years w hich began after December 31, 2020. (Section 2305 of H.R. 1319; March 11, 2021).
[413] *Supra* note, **Error! Bookmark not defined.**
[414] *Id.*

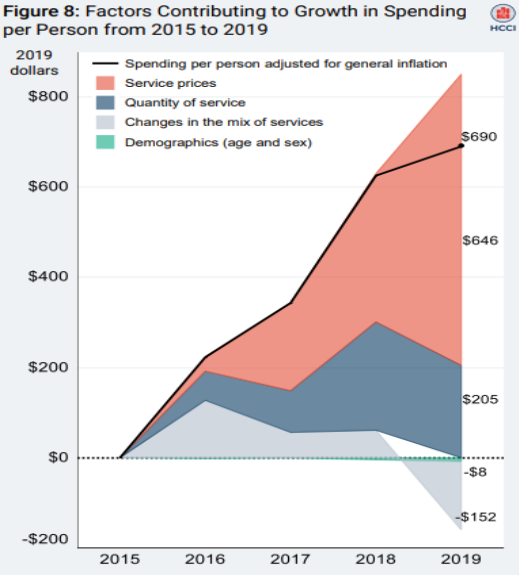


NOTE: Average annual growth rates are from previous year shown.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. Health spending per person in the U.S. was $12,914 in 2021 and increased for 2022 to $13,493, more than $5,000 greater than any other high income nation.[416]

The Organization for Economic Cooperation Development estimated that total spending in 2019 in its member countries averaged 8.8 percent of GDP, compared with 16.8 percent in the U.S.[417] One study found that United States commercial health spending per enrollee increased by 21.8% between 2015 and 2019.[418] The rising prices of health care services accounted for approximately two-thirds of that growth, with prices for prescription drugs, provider services (physical examinations, screenings and procedures) and inpatient and outpatient care rising by 18.3%.[419] The following chart details the factors contributing to the growth in spending, per capita, in the United States:[420]

[416] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How does health spending in the U.S. compare to other countries?*, February 9, 2023, available at (https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ last viewed on January 22, 2024). The average amount spent on health per person in comparable countries – $6,125 – is less than half of what the U.S. spends.
[417] *Supra*, note **Error! Bookmark not defined.**.
[418] Health Care Cost Institute, *2019 Health Care Cost and Utilization Report*, pg. 2, available at https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf (last viewed January 22, 2024).
[419] *Id.*
[420] *Supra*, note **Error! Bookmark not defined.**



Health Care Price Transparency

This country is experiencing significant changes in the payment and delivery of health care services. Consumers bear a greater share of health care costs, and more consumers participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs, and insurance coverage.

Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[421] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and, identifies a consumer's out-of-pocket cost.[422] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[423] Indeed, the definition of the price or cost of health care has different meanings depending on who is incurring the cost.[424]

Employee Out of Pocket Costs

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the *2023 Kaiser Family Foundation Employer Health Benefits Survey*, 30 percent of Americans with private insurance were enrolled in a HDHP in 2023.[425] Additionally, employees in most firms, 77 percent, do not have a choice of health plans or benefit options, including 26 percent who are in firms where the only offer is a high deductible plan with savings option (HDHP/SO).

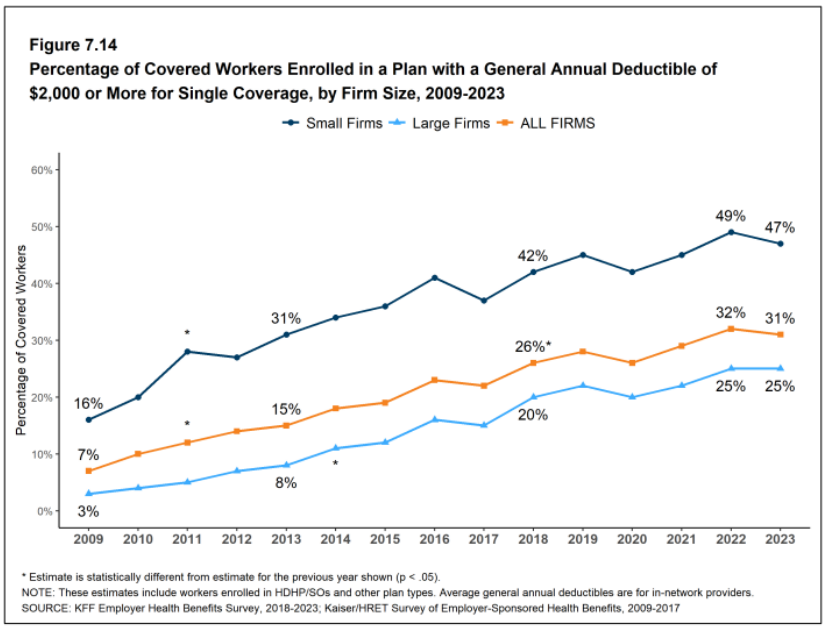
Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. For 2023, ninety percent of

[421] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at https://www.gao.gov/products/gao-11-791 (last viewed January 22, 2024).
[422] *Id.*
[423] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, April 10, 2014 available at https://www.hfma.org/payment-reimbursement-and-managed-care/pricing/22274/ (last viewed January 22, 2024).
[424] *Id.*
[425] The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 79, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last viewed on January 22, 2024).

covered workers had a general annual deductible[426] for single coverage that must be met before most services are paid for by their health plan.[427] Ten years ago, the percentage of covered workers with a general annual deductible was 78 percent and 85 percent five years ago.[428]

Among covered workers with a general annual deductible, the 2023 average deductible amount for single coverage across all plan types is $1,735 which is similar to the average amount for 2022 of $1,763.[429] Deductibles can differ greatly by a number of factors, including firm size, region, or whether a plan incorporates other cost sharing provisions. Looking at costs by firm size in 2023; the average amount for single coverage was $2,434 in small firms and $1,478 in large firms.[430]

The 2023 plan deductible averages reflect moderate reductions from the average deductibles for small and large group plans in 2022 which were $2,543 and $1,493, respectively. Seventy-four percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 58 percent in large firms;[431] a similar pattern exists for those in plans with a deductible of at least $2,000 (47 percent for small firms vs. 25 percent for large firms). The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2009 through 2023.[432]



From 2013 to 2023, the average premium contribution required of covered workers with family coverage increased 19 percent and if broken down by just the last 5 years, the average worker contribution towards family health insurance coverage has increased by 22 percent compared to a 27 percent in workers' wages and 21 percent inflation.[433] The dramatic increases in the costs of health care in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

Employer contributions to coverage vary widely based on the type of coverage and plan. For small plans, 30 percent of employers pay the entire premium for individual coverage of their workers whereas this is only the case with 6 percent of large firm employers. For family coverage, however, only small

[426] The term "general annual deductible" means a deductible which applies to both medical and pharmaceutical benefits and which must be met by the insured individual before most services are covered by the health plan. *See* The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 106, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last viewed on January 22, 2024).
[427] *Id.*
[428] *Id.*, and FIG. 7.2 at p.108.
[429] *Id.*
[430] *Id.* at 107-108.
[431] *Id.* at 115 and FIG. 7.13.
[432] *Id.*, at116 and FIG.7.14.
[433] *Id.* at 7.

firm employees contribute more than half the premium costs for family coverage, compared to 8 percent of covered workers in large firms.[434]

For workers in high deductible health plan plans (HDHP), they may receive contributions from their employer into a savings account which may be used to reduce cost sharing amounts or to cover items not included in the employer's benefit package. In 2023, 7 percent of covered workers with a HDHP with a health reimbursement arrangement (HRA)[435] and 4 percent of covered workers in a Health Savings Account (HSA) – qualified HDHP received an employer contribution to their accounts that was greater than or equal to their annual deductible.[436] An HRA is defined by the Internal Revenue Service (IRS) as an account-based group health plan provided by an employer to provide for the reimbursement of medical expenses under IRS Code section 213(d) and is subject to maximum, fixed-dollar amounts for reimbursements within a specified period, usually a plan year.[437]

For those employees with an HDHP with an HRA, 12 percent of those workers received an employer contribution that if the amount had been applied to the worker's annual deductible, the remaining deductible would be less than $1,000.[438] HSA-qualified HDHPs are required by federal law to have an annual out of pocket maximum of no more than $7,500 for single coverage and $15,000 for family coverage. For HDHPs with an HRA option that are not grandfathered plans, the out of pocket maximum in 2023 was $9,100 for single coverage and $18,200 for family coverage. The average out of pocket maximum for 2023 was $5,456 for HDHP/HRAs and $4,415 for HSA-qualified HDHPs.[439]

Such funding arrangements are more likely to be found in firms with more than 200 workers (57 percent) than smaller firms (29 percent).[440] Enrollment has increased over the past 10 years in HDHP/SOs growing from 10 percent of covered workers in 2013 to 29 percent in 2023.[441]

National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." As noted by the authors, American consumers have historically found it difficult to comparison shop for health care services as information about pricing and service delivery is buried in secrecy and shrouded in medical jargon once information is uncovered by the consumer.[442] The authors also provide a two-step definition of price transparency: A process which, first, more generally describes price transparency as the readily available price data for the purposes of price comparison, and a second which focuses on different audiences who use that data and the unique needs of those different audiences.[443]

This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

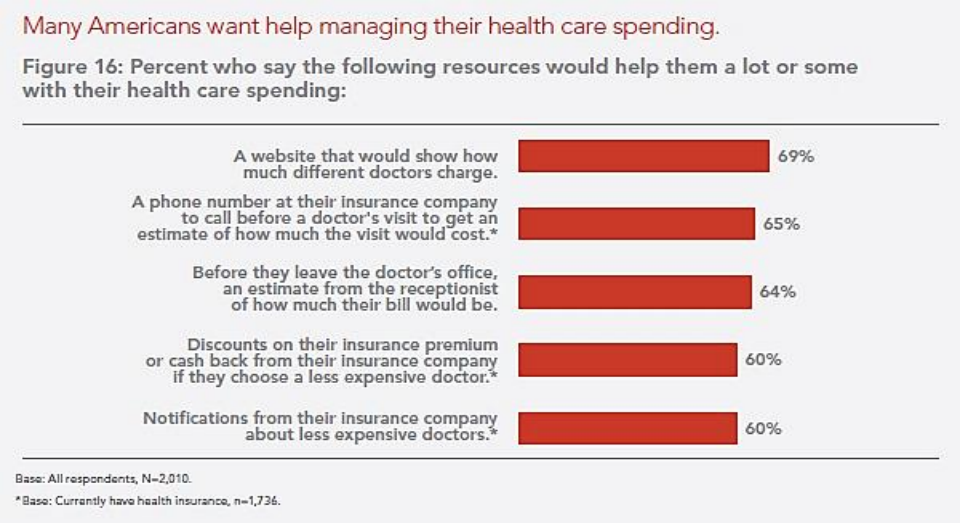
- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.

[434] *Id*. at 9.
[435] A high deductible health plan with a savings option (HDHP/SOs) are health plans which have a deductible of at least $1,000 for individual coverage and $2,000 for family coverage which are paired with a health reimbursement account (HRA), or a high deductible health plan that is considered by federal requirements to be a qualified HDHP. Funds in these savings accounts are pre-tax dollars which may be used to cover out-of-pocket medical expenses and other plan cost sharing.
[436] *Supra*, note **Error! Bookmark not defined.** at 12.
[437] *Health Reimbursement Arrangements and Other Account Based Group Health Plans*, Supplementary Information – Final Rule, 84 Fed.Reg.119, 28887 (June 20, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf (last viewed January 22, 2024).
[438] *Supra*, note **Error! Bookmark not defined.** at 12.
[439] *Supra*, note **Error! Bookmark not defined.** at 147.
[440] *Supra*, note **Error! Bookmark not defined.** at 140.
[441] *Supra*, note **Error! Bookmark not defined.** at 142.
[442] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, p. 3, available at https://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (last viewed January 22, 2024) .
[443] *Id.*

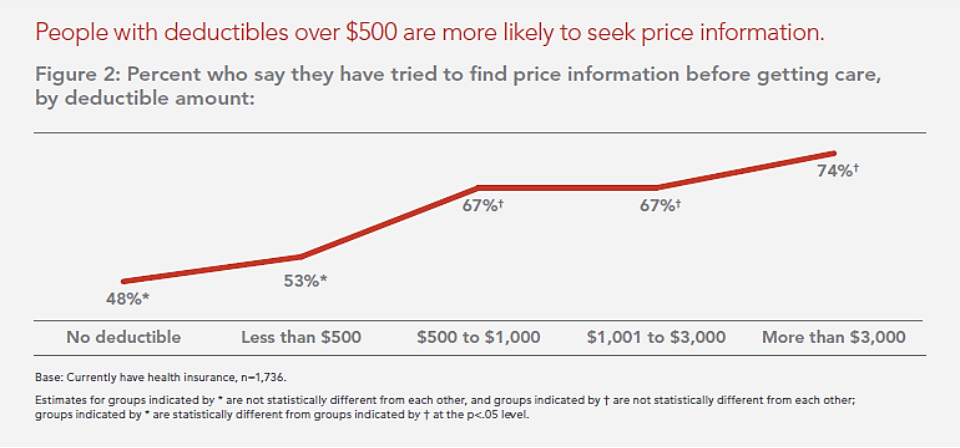
- Expand state-based all-payer health claims databases, which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[444]

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[445]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[446]



One study in 2014, which included a survey of more than 2,000 adults from across the country, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[447] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[448]



The individuals who compared prices stated that such research affected their health care choices and saved them money.[449] In addition, the study found that most Americans do not equate price with quality of care. Seventy-one percent do not believe higher price reflects higher level care quality and 63

[444] *Id.*
[445] *Id.*, at. 1.
[446] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/reports/how-much-will-it-cost-how-americans-use-prices-in-health-care/ (last viewed January 22, 2024).
[447] *Id.*, at 3.
[448] *Id.*, pg. 13.
[449] *Id.*, pg. 4.

percent do not believe that lower price is indicative of lower level care quality.[450] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[451] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[452]

Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[453] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[454] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[455] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[456] Estimates must be written in language "comprehensible to an ordinary layperson."[457] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[458] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[459]

Currently, under the Patient's Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

[450] Supra, FN 14.
[451] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, pg. 4, available at https://www.air.org/sites/default/files/Resource-rwjf402126.pdf (air.org)(last viewed January 22, 2024).
[452] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568 ,available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.1168 (last viewed on January 22, 2024).
[453] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[454] S. 381.026(3), F.S.
[455] S. 381.026(4)(c), F.S.
[456] S. 381.026(4)(c)3., F.S.
[457] *Id.*
[458] *Id.*
[459] S. 381.026(4)(c)5., F.S.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[460]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[461] to publish a schedule of charges for the medical services offered to patients.[462] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[463] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[464] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[465]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[466] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[467] The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[468]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[469] must provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[470] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

[460] S. 381.0261, F.S.
[461] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[462] S. 381.026(4)(c)3., F.S.
[463] *Id.*
[464] *Id.*
[465] S. 381.026(4)(c)4., F.S.
[466] S. 395.107(1), F.S.
[467] S. 395.107(2), F.S.
[468] S. 395.107(6), F.S.
[469] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[470] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity. For more information, see https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last viewed January 22, 2024).

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[471] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[472] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[473]

The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[474]

Federal Price Transparency Laws and Regulations

Congress and federal regulatory agencies recently took steps to improve the quantity and quality of health care cost information available to patients.

Hospital Facility Transparency

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[475] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges and a consumer-friendly presentation of prices for at least 300 shoppable health care services. The regulations became effective on January 1, 2021.[476]

The regulations define a shoppable service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable point estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[477] Very early indications suggest that there are varying levels of compliance with the new rules among hospital facilities.[478]

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[471] S. 395.301, F.S.
[472] S. 408.05(3)(c), F.S.
[473] *Id.*
[474] S. 456.0575(2), F.S.
[475] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019)(codified at 45 CFR Part 180).
[476] *Id.*
[477] *Supra*, note **Error! Bookmark not defined.**.
[478] ADVI, "*Implementation of Newly Enacted Hospital Price Transparency*," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf.

Health Insurer Transparency

On October 29, 2020, the federal Departments of Health and Human Services, Labor, and Treasury finalized regulations[479] imposing new transparency requirements on issuers of individual and group health insurance plans.

Estimates

Central to the new regulations is a requirement for health plans to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurance plans must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[480]

Each health plan will be required to establish an online shopping tool that will allow insureds to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services. This requirement is scheduled to take effect on January 1, 2023. Beginning in 2024, health plans will need to provide personalized cost-sharing information to patients across the full range of covered health care services.[481]

Medical Loss Ratio

The regulations also clarify the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by the Patient Protection and Affordable Care Act (PPACA). MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to promote efficiency among insurers.[482] The PPACA established minimum MLR requirements for group and individual health insurance plans.[483] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[484] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[485]

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program shall be counted as medical expenditures.[486] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by PPACA. In theory, this policy should provide an additional incentive for insurers who have not already done so to adopt shared savings programs.

The Federal No Surprises Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[487] The No Surprises Act includes a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act went into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor were tasked with issuing regulations and guidance to implement a number of the provisions.[488]

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[479] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).
[480] Trump Administration Finalizes Transparency Rule for Health Insurers," Health Affairs Blog, November 1, 2020. Available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last viewed on January 22, 2024).
[481] *Supra*, note 72.
[482] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last viewed on January 22, 2024).
[483] PPACA s. 1001; 42 U.S.C. 300gg-18.
[484] *Supra*, note **Error! Bookmark not defined.**.
[485] *Id.*
[486] 45 CFR Part 158.
[487] PL 116-260. The No Surprises Act is found in Division BB of the Act.
[488] *Id.*

Estimates – Facilities

In the realm of price transparency, the No Surprises Act establishes the concept of an "advanced explanation of benefits" that combines information on charges provided by a hospital facility with patient-specific cost information supplied by a health insurance plan. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured).[489]

Estimates – Health Plans

Once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop a more detailed and "advanced explanation of benefits". This personalized cost estimate must include the following:

- An indication of whether the facility participates in the patient's health plan network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health plan;
- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's health plan;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (i.e., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[490]

Furthermore, the Act directs the Secretary of Health and Human Services (HHS) to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[491]

The new requirements placed on hospitals and health plans by the No Surprises Act are cumulatively intended to provide patients with increased certainty about the total and out-of-pocket costs associated with health care services. In turn, patients may be more equipped to seek out cost-effective care and avoid unforeseen costs that can lead to financial strain,
Many hospitals currently do not comply with the federal transparency requirements. A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[492] Further, an August 2022 review of 2,000 hospitals found that 16 percent complied with all transparency requirements.[493] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[494] Another review of more than 6,400 hospitals showed wide-spread non-compliance with the federal transparency rule- more than 63 percent of hospitals were not in compliance as of the report date.[495] According to that same review, only 38 percent of Florida hospitals were in compliance.[496] The first fines were not levied by federal CMS against Northside until almost 18 months

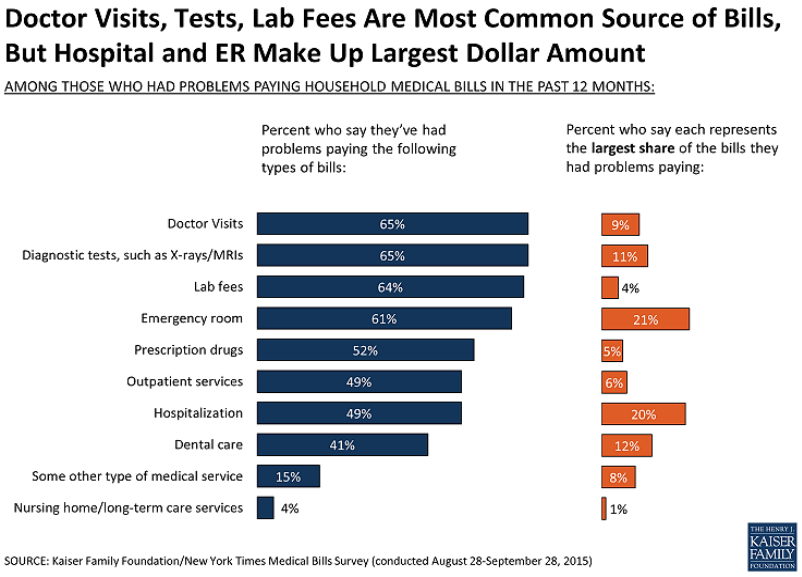
[489] PL 116-260, Division BB, Section 112.
[490] PL 116-260, Division BB, Section 111.
[491] Supra, FN 80.
[492] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last viewed on January 22, 2024).
[493] Patients' Rights Advocates, *Third semi-annual hospital transparency compliance report, 2022*, available at https://www.patientrightsadvocates.org/august-semi-annual-compliance-report-2022 (last reviewed January 22, 2024)..
[494] *Id.*
[495] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care*, pg. 3, August 2022, available at https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last viewed on January 22, 2024). As of the date of the report, only two hospitals to date had been fined for noncompliance with the transparency rule, both of which were in Georgia's Northside Hospital System.
[496] *Id.* at 4.

after the rule's effective date and even when levied, the total amount of those fines were less than 0.1 percent of Northside Hospital system's total gross revenues[497].

Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt.[498] A 2007 study suggested that illness and medical bills contributed to 62.1 percent of all personal bankruptcies filed in the United States during that year.[499] A more recent analysis, which considered only the impact of hospital charges, found that 4 percent of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[500] Four in ten U.S. adults have some form of health care debt,[501] including one in 8 people who reported health care debts of at least $10,000 or more in a 2022 Kaiser Family Foundation poll.[502]

About half of adults – including three in ten who do not currently have health care debt – are vulnerable to falling in the debt, saying they would be unable to pay a $500 unexpected medical bill without borrowing money.[503] While about a third of adults with health care debt owe less than $1,000, even small amounts of debt can have significant financial consequences for some.[504] Though a third of those with current debt expect to pay it off within a year and about a quarter expect to pay it within one to two years, nearly one in five adults with health care debt think they will never be able to pay it off.[505]



Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying or having an inability to pay medical bills in the past 12 months.[506] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even

[497] *Id*. at 4.
[498] Kaiser Health News, *Diagnosis: Debt – 100 Million People in America Are Saddled with Health Care Debt*, June 16, 2022, available at https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ (last viewed on January 22, 2024).
[499] David U. Himmelstein, et al. *"Medical Bankruptcy in the United States, 2007: Results of a National Study."* *American Journal of Medicine* 2009; 122: 741-6. available at https://www.amjmed.com/article/S0002-9343(09)00404-5/abstract.
[500] Carlos Dobkin, et al. *"Myth and Measurement: The Case of Medical Bankruptcies."* *New England Journal of Medicine* 2018; 378:1076-1078. Available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604.
[501] Lopes, L., Kearney, A., et al, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, June 16, 2022 (using results from the Kaiser Family Foundation Health Care Debt Survey), available at https://www.kff.org/health-costs/report/kff-health-care-debt-survey/ (last viewed on January 22, 2024).
[502] *Id.*
[503] *Id.*
[504] *Id.*
[505] *Id.*
[506] The Henry J. Kaiser Family Foundation, *"The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey."* January 5, 2016, available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the- kaiser-family-foundationnew-york-times-medical-bills-survey/(last viewed on January 22, 2024)

patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[507]

Among those who reported problems paying medical bills, 66 percent said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that had accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like pneumonia and flu (9 percent).[508]

More than two thirds of hospitals sue or take other legal action against patients with outstanding bills. Nearly 25 percent sell patient medical debt to collection agencies, who in turn can pursue patients for years to collect on unpaid bills. Further, one in five providers deny nonemergency care to people with outstanding medical debt.

Further polling results contained in the 2022 Kaiser report also showed that families who had experienced medical debt problems were also more likely to ask about the cost of a medical service or doctor's office visit beforehand than someone who had not had such difficulties (49 percent compared to 34 percent). Such families were also much more likely to shop around for services for the best price (34 percent compared to 17 percent) and to attempt to negotiate a lower rate before receiving a health care service (22 percent compared to six percent). Impacted families with medical debt also reported a higher rate of being asked to pay for health care services up front before services would be delivered.[509]

Personal Credit Ratings

Recognizing the inherent difficulties associated with medical debt, the three major credit rating companies in July 2023 agreed to exclude from an individual's credit report medical debts that have been paid off and unpaid medical debts less than $500. This action followed a 2015 settlement agreement with several state Attorney Generals which had established a minimum time period of 180 days before a medical debt could be report to a credit agency.[510] The national credit reporting companies announced that this time period would be expanded voluntarily to one year in 2022.

With the 2023 agreement and the $500 capped medical debt collection, regulators expect that the majority of medical debt will fall under this dollar threshold, although geographic differences in the average amount of medical debt across the county exist as do higher amounts in neighborhoods that are majority Black or Hispanic and have lower median incomes.[511]

When a person first takes out a line of credit as an individual—a first credit card or a loan to pay for college, for example—this begins a personal credit history and the process of building a personal credit score. This score is linked to a person's Social Security Number.

From then on, the score reflects one's personal financial history. If a person always pays bills on time, does not use too much of the available credit at once, and avoids negative information like foreclosures and charge-offs, the person will develop a good personal credit score, also known as a FICO score. If, instead, one carries a balance on lines of credit, fails to develop a diverse mix of credit sources—different credit cards, an automobile loan, and a mortgage, for example—and accrues many "hard inquiries" on your credit score (which occurs when upon application for a new source of credit), the FICO score will be low. Personal credit scores generally range 350-800 with 800 being a "perfect" score.

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[507] *Id.*a
[508] *Id.*
[509] *Id.* at 23.
[510] Consumer Financial and Protection Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports,* July 27, 2022, available at https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/ (last viewed on January 22, 2024).
[511] *Id.*

In 2018-2020, more than a quarter of the nation's largest hospitals and health systems pursued nearly 39,000 legal actions regarding consumer medical debt.[512]

Medical Debt Collection Process

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[513] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[514]

In addition to the protection from creditors contained in the Florida Constitution, chapter 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[515] proceeds from life insurance policies;[516] wages or unemployment compensation payments due certain deceased employees;[517] disability income benefits;[518] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[519] $1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.[520]

Bankruptcy is a means by which a person's assets are liquidated in order to pay the person's debts under court supervision. The United States Constitution gives Congress the right to uniformly govern bankruptcy law.[521] Bankruptcy courts are operated by the federal government. A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Certain property is deemed "exempt" from the bankruptcy case, and may be kept by the debtor without being subject to creditor claims. The Bankruptcy Code provides for exempt property in a bankruptcy case.[522] In general, a debtor may choose to utilize the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law and thereby insist that debtors only utilize state law exemptions.[523] Florida, like most states, has made the opt-out election to prohibit the use of the federal exemptions and require that debtors may only use state law exemptions.[524]

Statutes of Limitations

A statute of limitations bars a lawsuit's filing after a certain amount of time elapses following an injury.[525] This time period typically begins to run when a cause of action accrues (that is, on the date of the

[512] Using data from Johns Hopkins University, study authors analyzed the top 100 hospitals in the U.S. (by revenue) to measure debt collection methods and frequency, average charges markups and billing scores, and compare that data to safety grades and charity care ratings, by hospital type (government, nonprofit and for-profit). See, "How America's top hospitals hound patients with predatory billing", July 2021, available at https://www.axios.com/hospital-billing (last viewed March 26, 2023). Twelve Florida hospitals were included in the analysis, with a wide range of scores in each category.
[513] Art. X, s. 4(a), Fla. Const.
[514] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[515] S. 222.11, F.S.
[516] S. 222.13, F.S.
[517] S. 222.15, F.S.
[518] S. 222.18, F.S.
[519] S. 222.22, F.S.
[520] S. 222.25, F.S.
[521] Art. 1, s. 8, cl. 4, U.S. Const.
[522] 11 U.S.C. s. 522.
[523] 11 U.S.C. s. 522(b).
[524] S. 222.20, F.S.
[525] Legal Information Institute, Statute of Limitations, https://www.law.cornell.edu/wex/statute_of_limitations (Last visited January 22, 2024).

injury), but may also begin to run on the date the injury is discovered or on which it would have been discovered with reasonable efforts.[526] In other words, a statute of limitations bars the available civil remedy if a lawsuit is not timely filed after an injury.

Chapter 95, F.S., contains the bulk of Florida's statutes of limitations. Specifically, s. 95.11, F.S., details a variety of statutes of limitation for legal actions other than for recovery of real property. Some of the limitations require legal actions to be commenced as follows:

- WITHIN TWENTY YEARS.—An action on a judgment or decree of a court of record in this state.[527]
- WITHIN FIVE YEARS.—
    - An action on a judgment or decree of any court, not of record, of this state or any court of the United States, any other state or territory in the United States, or a foreign country.
    - A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (5)(e), s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (5)(h).
    - An action to foreclose a mortgage.
    - An action alleging a willful violation of s 448.110.
    - Notwithstanding paragraph (b), an action for breach of a property insurance contract, with the period running from the date of loss.[528]
- WITHIN FOUR YEARS.—
    - An action founded on negligence.
    - An action relating to the determination of paternity, with the time running from the date the child reaches the age of majority.
    - An action founded on the design, planning, or construction of an improvement to real property, with the time running from the date of actual possession by the owner, the date of the issuance of a certificate of occupancy, the date of abandonment of construction if not completed, or the date of completion of the contract or termination of the contract between the professional engineer, registered architect, or licensed contractor and his or her employer, whichever date is latest, with some exceptions.
    - An action to recover public money or property held by a public officer or employee, or former public officer or employee, and obtained during, or as a result of, his or her public office or employment.
    - An action for injury to a person founded on the design, manufacture, distribution, or sale of personal property that is not permanently incorporated in an improvement to real property, including fixtures.
    - An action founded on a statutory liability.
    - An action for trespass on real property.
    - An action for taking, detaining, or injuring personal property.
    - An action to recover specific personal property.
    - A legal or equitable action founded on fraud.
    - A legal or equitable action on a contract, obligation, or liability not founded on a written instrument, including an action for the sale and delivery of goods, wares, and merchandise, and on store accounts.
    - An action to rescind a contract.
    - An action for money paid to any governmental authority by mistake or inadvertence.
    - An action for a statutory penalty or forfeiture.
    - An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (4), (5), and (7).
    - Any action not specifically provided for in these statutes.
    - An action alleging a violation, other than a willful violation, of s. 448.110.[529]

[526] *Id.*
[527] S. 95.11(1), F.S.
[528] S. 95.11(2), F.S.

- WITHIN TWO YEARS.—
  - An action founded on negligence.
  - An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
  - An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence. However. the limitation of actions herein for professional malpractice shall be limited to persons in privity with the professional.
  - An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.
  - An action for wrongful death.
  - An action founded upon a violation of any provision of chapter 517, with the period running from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 5 years from the date such violation occurred.
  - An action for personal injury caused by contact with or exposure to phenoxy herbicides while serving either as a civilian or as a member of the Armed Forces of the United States during the period January 1, 1962, through May 7, 1975; the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
  - An action for libel or slander.[530]
- WITHIN ONE YEAR.—
  - An action for specific performance of a contract.
  - An action to enforce an equitable lien arising from the furnishing of labor, services, or material for the improvement of real property.
  - An action to enforce rights under the Uniform Commercial Code—Letters of Credit, chapter 675.
  - An action against any guaranty association and its insured, with the period running from the date of the deadline for filing claims in the order of liquidation.
  - Except for actions governed by s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), an action to enforce any claim against a payment bond on which the principal is a contractor, subcontractor, or sub-subcontractor as defined in s. 713.01, for private work as well as public work, from the last furnishing of labor, services, or materials or from the last furnishing of labor, services, or materials by the contractor if the contractor is the principal on a bond on the same construction project, whichever is later.
  - Except for actions described in subsection (8), a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.
  - Except for actions described in subsection (8), an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's confinement.
  - An action to enforce a claim of a deficiency related to a note secured by a mortgage against a residential property that is a one-family to four-family dwelling unit. The limitations period shall commence on the day after the certificate is issued by the clerk of court or the day after the mortgagee accepts a deed in lieu of foreclosure.[531]

Direct Health Care Agreements

Created in Florida law by the 2008 Legislature,[532] *direct health care agreements*, are non-insurance contracts between certain, statutorily designated health care providers or groups of providers and patients. Such agreements are not subject to the Florida Insurance Code and are not regulated by the

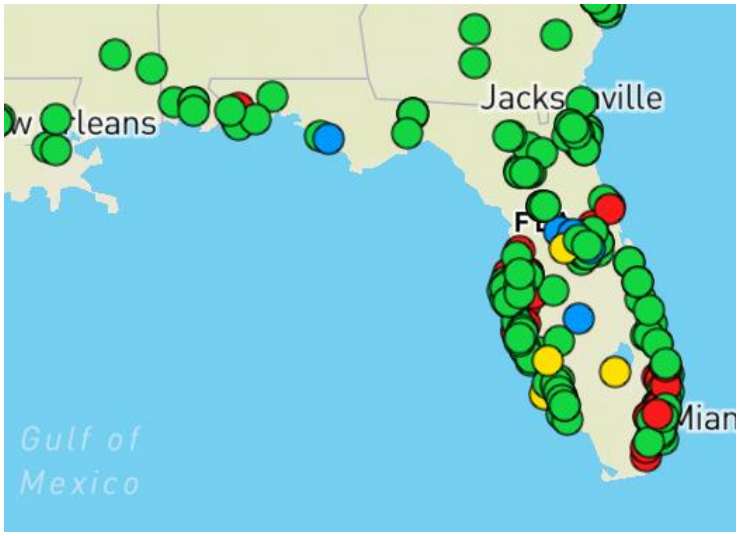
[529] S. 95.11(3), F.S.
[530] S. 95.11(4), F.S.
[531] S. 95.11(5), F.S.
[532] Ch. Law 2018-89, L.O.F.

Department of Financial Services or the Office of Insurance Regulation. The direct provider arrangement eliminates third party payors and instead creates a contractual relationship between the health care provider and the patient usually with a small monthly fee (usually around $70 per individual) for access to the designated scope of benefits.

These agreements must adhere to specific statutory requirements to be a valid agreement. The requirements for a valid agreement are for the agreement to:

- Be in writing.
- Be signed by the health care provider or an agent of the health care provider and the patient, the patient's legal representative, or the patient's employer.
- Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.
- Describe the scope of health care services that are covered by the monthly fee.
- Specify the monthly fee and any fees for health care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.
- Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health care provider ceases to offer health care services for any reason.
- Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "This agreement is not health insurance and the health care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440.[533]

The Direct Primary Care Coalition reports over 1,000 associated practices.[534] On the map below, each green dot equals a pure direct primary care model, a red dot is a hybrid model, and a blue dot equals an onsite model. A provider with a hybrid model may have a mix of both direct primary care patients as well as other patients.



Patients who seek services under these agreements may see health care providers for any services for which the provider is licensed and has the competency and training to provide.[535] In Florida, state law allows direct health care arrangements to include: Currently, direct health care arrangements are limited to those defined as a "health care provider", and as designated by a specific licensure type. Those provider types are:

- Chapter 458 (medical doctors);

[533] S. 624.67(4)(a)-(h), F.S.
[534] Direct Primary Care Coalition, *Direct Primary Care Mapper,* available at https://mapper.dpcfrontier.com/ (last viewed January 22, 2024).
[535] S. 624.67(1)(c), F.S.

- Chapter 459 (osteopathic doctors);
- Chapter 460 (chiropractic physicians);
- Chapter 461 (podiatrists);
- Chapter 464 (nursing, including advanced or specialized nursing practice, advanced practice registered nurse, licensed practice nurse, or registered nurse);
- Chapter 466 (dental or dental hygienist), or
- A health care group practice, who provides health care services to patients.[536]

Effect of the bill - Health Care Price Transparency and Medical Debt

The bill increases patient access to health care cost information, and offers a measure of protection from unreasonable and burdensome medical debt. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into the Florida Statutes; in doing so, the bill requires compliance by facilities and insurers as a condition of state licensure, thus ensuring that these provisions will be fully adopted and adequately enforced in Florida.[537]

Facility Price Transparency

Facility Billing Estimates

The bill requires that all patients receive cost-of-care information prior to receiving scheduled, nonemergency treatment in hospitals and ambulatory surgical centers, and from physicians providing services in those facilities.

At present, licensed facilities are required to provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition, *upon request of the patient*. The bill makes these personalized estimates mandatory, rather than dependent on patient requests. A facility must submit the estimate of charges to a patient's health plan at least 3 business days before a service is to be furnished, according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after the service is scheduled;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after a service is scheduled.

By requiring facilities to provide a good-faith estimate of charges to each patient in advance of treatment, the bill mirrors the requirements of the federal No Surprises Act. Compliance with the Act was required by January 1, 2022.

Shoppable Services

The bill requires each licensed hospital and ambulatory surgical center to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website. A facility that provides less than 300 distinct services will be required to post standard charges for each service it does provide.

The bill requires facilities to post pricing information for shoppable services in accordance with the definition of "standard charges" established in federal rule.[538] This information extends beyond the traditional concept of charges to include negotiated and actual prices paid for selected services. For each shoppable service, a hospital must disclose the following pricing benchmarks:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;

[536] S. 624.27(1)(b), F.S.
[537] SS. 395.003, 395.301, 408.802, 624.401, and 641.22, F.S.
[538] *Supra*, note **Error! Bookmark not defined.**.

- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This bill is intended to mirror the shoppable services requirement included in the hospital facility transparency regulations finalized by the CMS in 2019. The bill requires facilities to disclose the relevant cost information as a condition of state licensure, which should result in uniform compliance among facilities.

Facility Medical Debt Collection

The bill prohibits hospitals and ASCs from engaging in any "extraordinary collection actions" against a patient prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, for 30 days after notifying a patient in writing that a collections action will commence, and while the patient is negotiating in good faith the final amount of the bill or is complying with the terms of a payment plan with the facility. For purposes of the provision, "extraordinary collection action" means any action that requires a legal or judicial process, including:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

The bill also establishes a new set of debt collection exemptions in chapter 222, F.S. that apply explicitly to debt incurred as a result of medical services provided in hospitals, ambulatory surgical centers, or urgent care centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill increases the ceiling on the debt collection exemptions, when the debt results from services provided in a hospital facility or ambulatory surgical center, as follows:

- To $10,000 interest in a single motor vehicle (versus the current law exemption of $1,000);
- To $10,000 interest in personal property, provided that a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution (versus the current law exemption of $4,000).

The bill also requires each hospital and ASC to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within 7 business days.

Lastly, the bill creates a three-year statute of limitations for any legal action related to medical debt for services rendered by a facility licensed under chapter 395, F.S., such as hospitals, ambulatory surgical centers, and urgent care centers. The statute of limitations begins running on the date that the facility refers the debt to a third-party collection entity.

Insurer Price Transparency

Shared Savings Programs

The bill establishes an accounting standard to remove a barrier to shared savings incentive programs. It specifies that insurer shared savings payments to patients shall be counted as medical expenses for rate development and rate filing purposes.[539] This change aligns Florida law with the federal regulations that became final in 2020.[540]

[539] Current law indicates that a shared savings incentive offered by a health plan is "not an administrative expense for rate development or rate filing purposes," but does not affirmatively categorize the expense. SS. 627.6387, 627.6648, and 641.31076, F.S.
[540] *Supra*, note **Error! Bookmark not defined.**.

Advanced Explanation of Benefits

The bill requires health plans to issue an advance explanation of benefits statement when a covered patient schedules a service in a hospital or ambulatory surgical center. This requirement builds on the facility charges estimate provision in the bill. Once a facility notifies a health plan that a patient has scheduled a medical service, the health plan must prepare a personalized estimate of costs for the patient in accordance with the federal No Surprises Act. A health plan must provide an advanced explanation of benefits to the patient according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after receiving the estimate of charges from the facility;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after receiving the estimate of charges from the facility.

Health insurers and HMOs were required comply with the federal Act by January 1, 2022.

Cash Price Communication

Under the Public Health Services Act, section 2799A-9(a)(2), health insurance issuers that offer individual health insurance coverage are prohibited from entering into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the issuer from—

(1) Providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or
(2) Sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in (1) with a business associate, consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA.[541]

These regulations further restrict group health plans and health plan issuers from restricting the release of provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage.[542]

The first attestation of compliance from health plans and issuers was due on December 31, 2023 and will be due annually thereafter.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.4018, F.S., relating to physician workforce assessment and development.
Section 2: Amends s. 381.4019, F.S., relating to dental student loan repayment program.
Section 3: Amends s. 1009.65, F.S., relating to medical education reimbursement and loan repayment program.
Section 4: Creates s. 381.4021, F.S., relating to student loan repayment programs reporting.
Section 5: Creates s. 381.9855, F.S., relating to health care screening and services grant program.
Section 6: Amends s. 383.2163, F.S., relating to telehealth minority maternity care pilot programs.
Section 7: Amends s. 383.302, F.S., relating to definitions.
Section 8: Creates s. 383.3081, F.S., relating to advanced birth center designation.
Section 9: Amends s. 383.309, F.S., relating to minimum standards for birth centers; rules and enforcement.
Section 10: Amends s. 383.313, F.S., relating to performance of laboratory and surgical services; use of anesthetic and chemical agents.

[541] Centers for Medicare and Medicaid Services, *Gag Clause Prohibition Attestation Compliance,* https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/gag-clause-prohibition-compliance-attestation (last viewed January 22, 2024).
[542] *Id.*

Section 11: Creates s. 383.3131, F.S., relating to advanced birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.
Section 12: Amends s. 383.315, F.S., relating to agreements with consultants for advice or services; maintenance.
Section 13: Amends s. 383.316, F.S., relating to transfer and transport of clients to hospitals.
Section 14: Amends s. 383.318, F.S., relating to postpartum care for birth center clients and infants.
Section 15: Amends s. 394.455, F.S., relating to definitions.
Section 16: Amends s. 394.457, F.S., relating to operations and administration.
Section 17: Amends s. 394.4598, F.S., relating to guardian advocate.
Section 18: Amends s. 394.4615, F.S., relating to clinical records; confidentiality.
Section 19: Amends s. 394.4625, F.S., relating to voluntary admissions.
Section 20: Amends s. 394.463, F.S., relating to involuntary examination.
Section 21: Amends s. 394.4655, F.S., relating to involuntary outpatient services.
Section 22: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 23: Amends s. 394.4781, F.S., relating to residential care for psychotic and emotionally disturbed children.
Section 24: Amends s. 394.4785, F.S., relating to children and adolescents; admission and placement in mental facilities.
Section 25: Creates an unnumbered section of law, relating to Medicaid coverage of mobile crisis response services.
Section 26: Amends s. 394.875, F.S., relating to crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.
Section 27: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 28: Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 29: Creates s. 395.3011, F.S., relating to billing and collection activities.
Section 30: Amends s. 408.051, F.S., relating to Florida Electronic Health Records Exchange Act.
Section 31: Amends s. 409.909, F.S., relating to Statewide Medicaid Residency Program.
Section 32: Creates s. 409.91256, F.S., relating to Training, Education, and Clinicals in Health Funding Program.
Section 33: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 34: Amends s. 409.973, F.S., relating to benefits.
Section 35: Creates an unnumbered section of law, relating to Medicaid hospital care at home.
Section 36: Creates s. 456.0145, F.S., relating to Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.
Section 37: Amends s. 456.073, F.S., relating to disciplinary proceedings.
Section 38: Amends s. 456.076, F.S., relating to impaired practitioner programs.
Section 39: Creates s. 456.4501, F.S., relating to Interstate Medical Licensure Compact.
Section 40: Creates s. 456.4502, F.S., relating to Interstate Medical Licensure Compact; disciplinary proceedings.
Section 41: Creates s. 456.4504, F.S., relating to Interstate Medical Licensure Compact rules.
Section 42: Creates an unnumbered section of law, relating to Interstate Medical Licensure Compact fees.
Section 43: Amends s. 457.105, F.S., relating to licensure qualifications and fees.
Section 44: Amends s. 458.311, F.S., relating to licensure by examination; requirements; fees.
Section 45: Repeals s. 458.3124, F.S., relating to restricted license; certain experienced foreign-trained physicians.
Section 46: Amends s. 458.313, F.S., relating to licensure by endorsement; requirements; fees.
Section 47: Amends s. 458.314, F.S., relating to certification of foreign educational institutions.
Section 48: Amends s. 458.3145, F.S., relating to medical faculty certificate.
Section 49: Amends s. 458.315, F.S., relating to temporary certificate for practice in areas of critical need.
Section 50: Amends s. 458.317, F.S., relating to limited licenses.
Section 51: Amends s. 459.0075, F.S., relating to limited licenses.
Section 52: Amends s. 459.0076, F.S., relating to temporary certificate for practice in areas of critical need.

Section 53: Amends s. 464.009, F.S., relating to licensure by endorsement.
Section 54: Creates s. 464.0121, F.S., relating to temporary certificate for practice in areas of critical need.
Section 55: Amends s. 464.0123, F.S., relating to autonomous practice by an advanced practice registered nurse.
Section 56: Amends s. 464.019, F.S., relating to approval of nursing education programs.
Section 57: Amends s. 465.0075, F.S., relating to licensure by endorsement; requirements; fee.
Section 58: Amends s. 467.0125, F.S., relating to licensed midwives; qualifications; endorsement; temporary certificates.
Section 59: Amends s. 468.1705, F.S., relating to licensure by endorsement; temporary license.
Section 60: Repeals s. 468.213, F.S., relating to licensure by endorsement.
Section 61: Amends s. 468.3065, F.S., relating to certification by endorsement.
Section 62: Repeals s. 468.358, F.S., relating to licensure by endorsement.
Section 63: Amends s. 478.47, F.S., relating to licensure by endorsement.
Section 64: Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure endorsement.
Section 65: Amends s. 486.081, F.S., relating to physical therapist.
Section 66: Amends s. 491.006, F.S., relating to licensure or certifications by endorsement.
Section 67: Creates s. 458.3129, F.S., relating to Interstate Medical Licensure Compact.
Section 68: Creates s. 459.074, F.S., relating to Interstate Medical Licensure Compact.
Section 69: Amends s. 468.1135, F.S., relating to board of speech-language pathology and audiology.
Section 70: Amends s. 468.1185, F.S., relating to licensure.
Section 71: Amends s. 468.1295, F.S., relating to disciplinary proceedings.
Section 72: Creates s. 468.1335, F.S., relating to Practice of Audiology and Speech-Language Pathology Interstate Compact.
Section 73: Creates an unnumbered section of law, relating to Audiology and Speech-Language Pathology Interstate Compact fees.
Section 74: Amends s. 486.028, F.S., relating to license to practice physical therapy required.
Section 75: Amends s. 486.031, F.S., relating to physical therapist; licensing requirements.
Section 76: Amends s. 486.102, F.S., relating to physical therapist assistant; licensing requirements.
Section 77: Amends s. 486.107, F.S., relating to physical therapist assistant.
Section 78: Amends s. 490.006, F.S., relating to licensure by endorsement.
Section 79: Creates s. 486.112, F.S., relating to Physical Therapy Licensure Compact.
Section 80: Creates an unnumbered section of law, relating to Physical Therapy Licensure Compact fees.
Section 81: Amends s. 486.023, F.S., relating to board of physical therapy practice.
Section 82: Amends s. 486.125, F.S., relating to refusal, revocation, or suspension of license; administrative fines and other disciplinary measures.
Section 83: Amends s. 624.27, F.S., relating to direct health care agreements; exemption from code.
Section 84: Amends s. 95.11, F.S., relating to limitations other than for the recovery of real property.
Section 85: Creates s. 222.26, F.S., relating to additional exemptions from legal process concerning medical debt.
Section 86: Creates s. 627.446, F.S., relating to advanced explanation of benefits.
Section 87: Creates s. 627.447, F.S., relating to disclosure of discounted cash prices.
Section 88: Amends s. 627.6387, F.S., relating to shared savings incentive program.
Section 89: Amends s. 627.6648, F.S., relating to shared savings incentive program.
Section 90: Amends s. 641.31076, F.S., relating to shared savings incentive program.
Section 91: Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
Section 92: Amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.
Section 93: Amends s. 1002.32, F.S., relating to developmental research (laboratory) schools.
Section 94: Amends s. 1004.015, F.S., relating to Florida Development Council.
Section 95: Amends s. 1009.8962, F.S., relating to the Linking Industry to Nursing Education (LINE) fund.

Section 96: Amends s. 486.025, F.S., relating to powers and duties of the Board of Physical Therapy Practice.
Section 97: Amends s. 486.0715, F.S., relating to physical therapist; insurance of temporary permit.
Section 98: Amends s. 486.1065, F.S., relating to physical therapist assistant; issuance of temporary permit.
Section 99: Amends s. 395.602, F.S., relating to rural hospitals.
Section 100: Amends s. 458.316, F.S., relating to public health certificate.
Section 101: Amends s. 458.3165, F.S., relating to public psychiatry certificate.
Section 102: Amends s. 468.209, F.S., relating to requirements for licensure.
Section 103: Amends s. 468.511, F.S., relating to dietitian/nutritionist; temporary permit.
Section 104: Amends s. 475.01, F.S., relating to definitions.
Section 105: Amends s. 475.611, F.S., relating to definitions.
Section 106: Amends s. 517.191, F.S., relating to injunction to restrain violations; civil penalties; enforcement by Attorney General.
Section 107: Amends s. 787.061, F.S., relating to civil actions by victims of human trafficking.
Section 108: Appropriates funds to DOH for the Florida Reimbursement Assistance for Medical Education Program.
Section 109: Appropriates funds to DOH for the Dental Student Loan Repayment Program.
Section 110: Appropriates funds to DOH to expand statewide the telehealth minority maternity care program.
Section 111: Appropriates funds to AHCA to implement the TEACH Funding program.
Section 112: Appropriates funds to UF, FSU, FAU, and FAMU to implement lab school articulated health care programs.
Section 113: Appropriates funds to DOE to implement the LINE fund.
Section 114: Appropriates funds to AHCA for the Slots for Doctors Program.
Section 115: Appropriates funds to AHCA to provide to statutory teaching hospitals.
Section 116: Appropriates funds to AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping reimbursement methodology.
Section 117: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for dental care services.
Section 118: Appropriates funds to APD to provide a uniform iBudget Waiver provider rate increase; appropriates funds to AHCA to establish budget authority for Medicaid services.
Section 119: Appropriates funds to DCF to enhance crisis diversion through mobile response teams.
Section 120: Appropriates funds to DOH to implement the Heath Care Screening and Services Grant Program.
Section 121: Appropriates funds to AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
Section 122: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses.
Section 123: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers.
Section 124: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services.
Section 125: Appropriates funds and provides Full-Time Equivalent positions to AHCA to implement provisions in the bill.
Section 126: Appropriates funds and provides Full-Time Equivalent positions to DOH to implement provisions in the bill.
Section 127: Provides the bill will take effect upon becoming law, except as otherwise provided in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill provides the following appropriations for the 2024-2025 state fiscal year:

   - The sum of $30 million in recurring funds from the General Revenue Fund is appropriated to the DOH for FRAME.
   - The sum of $8 million in recurring funds from the General Revenue Fund is appropriated to the DOH for the DSLR Program.
   - The sum of $23,357,876 in recurring funds from the General Revenue Fund is appropriated to the DOH to expand statewide the telehealth minority maternity care program. This appropriation directs the DOH to establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The DOH must identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the regions, the neonatal intensive care unit levels of hospitals within the regions, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.
   - The sum of $25 million in recurring funds from the General Revenue Fund is appropriated to the AHCA to implement the TEACH Funding Program.
   - The sum of $2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs. Each state university will receive $500,000 from this appropriation.
   - The sum of $5 million in recurring funds from the General Revenue Fund is appropriated to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund.
   - The sums of $21,315,000 in recurring funds from the General Revenue Fund and $28,685,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA for the Slots for Doctors Program.
   - The sums of $42,630,000 in recurring funds from the Grants and Donations Trust Fund and $57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide to statutory teaching hospitals as defined in s. 408.07(46), F.S., meeting certain criteria, distributed according to specified parameters.
   - The sums of $57,402,343in recurring funds from the General Revenue Fund and $77,250,115 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology.
   - The sums of $83,456,275 in recurring funds from the General Revenue Fund and $112,312,609 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase.
   - The sum of $11,525,152 in recurring funds from the General Revenue Fund is appropriated to the Department of Children and Families to enhance crisis diversion through mobile response teams by adding an additional 16 mobile response teams to ensure coverage in every county.
   - The sum of $10 million in recurring funds from the General Revenue Fund is appropriated to the DOH to implement the Health Care Screening and Services Grant Program.

- The sum of $150,000 in nonrecurring funds from the General Revenue Fund and $150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
- Effective October 1, 2024, the sums of $14,888,903 in recurring funds from the General Revenue Fund and $20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for dental care services. The funds shall be held in reserve and released upon approval of a budget amendment pursuant to chapter 216, Florida Statutes. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $12,365,771 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,514,132 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $14,580,660 in recurring funds from the General Revenue Fund and $19,622,154 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $5,522,795 in recurring funds from the General Revenue Fund and $7,432,390 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective July 1, 2024, the sums of $585,758 in recurring funds and $1,673,421 in nonrecurring funds from the General Revenue Fund, $928,001 in recurring funds and $54,513 in nonrecurring funds from the Health Care Trust Fund, $100,000 in nonrecurring funds from the Administrative Trust Fund, $585,758 in recurring funds and $1,573,421 in nonrecurring funds from the Medical Care Trust Fund, and 20 full-time equivalent positions with the associated salary rate of 1,247,140 are provided to the Agency for Health Care Administration implement provisions in the bill.
- Effective July 1, 2024, the sums of $2,389,146 in recurring funds and $1,190,611 in nonrecurring funds from the General Revenue Fund, and $1,041,578 in recurring funds, $287,633 in nonrecurring funds from the Medical Quality Assurance Trust Fund, and 25 full-time equivalent positions with the associated salary rate of 1,739,740 are provided to the Department of Health implement provisions in the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have an indeterminate positive fiscal impact on health care practitioners who are able to participate in FRAME or the DSLR Program.

The bill may have an indeterminate positive fiscal impact for nonprofit entities that take advantage of the Health Care Screening and Services Grant program or anyone who is able to find free or reduced cost services through the DOH's portal.

The bill may have an indeterminate positive fiscal impact on facilities that participate in the TEACH program.

The bill may have an indeterminate positive fiscal impact on nursing schools that are able to participate in the LINE program due to changes made in the bill.

The bill could allow physicians who do not match for a residency following graduation from medical school to enter the Florida physician workforce faster and help reduce the health care provider shortage.

The bill may increase costs for facilities licensed under ch. 395, F.S., by requiring them to issue cost estimates for all non-emergency patients, but only if the facilities are out of compliance with the current federal requirement to provide these estimates.

Facilities may forego revenues due to the bill's limits on the use of extraordinary collection activities; however, some facilities may already be providing similar due process for patients, such that the bill will have little impact on them.

The bill may have a negative, but indeterminate, fiscal impact on health insurers and HMOs, due to the costs of producing advanced explanations of benefits for insureds and subscribers, triggered by the estimates provided by facilities, but only if these health plans are out of compliance with the current federal requirement to provide these to subscribers.

Additionally, the bill's increased dollar limit on personal property exemptions under ch. 222, F.S., may reduce revenues for medical service providers or their collection agents.

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:

Fees

Pursuant to Article 7 Section 19 of the Florida Constitution, new taxes or fees imposed by the Legislature must be approved by a two-thirds vote of both Legislative chambers in a bill containing no other subject. This requirement does not apply to fees authorized under current law.

There are no new fee provisions in the bill. The fee provisions contained within the bill move or reiterate existing fee requirements in current law. As such, the bill's provisions do not implicate Article 7 Section 19 of the Florida Constitution.

Compacts

The multistate compacts enacted in the bill authorize their commissions to adopt reasonable rules to effectively and efficiently achieve the purposes of the compacts, and these rules carry the force of law

in member states, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commissions.

The Legislature delegated similar rulemaking powers to compact commissions when it adopted the compact language for the Nurse Licensure Compact, Professional Counselors Licensure Compact, and the Psychology Interjurisdictional Compact into statute. The rules adopted by these compacts are now applicable to Florida without the Legislature's subsequent approval, similar to what the state would encounter with the enactment of multistate compacts under the bill and the included rulemaking provisions. In the case of these compacts, should Florida find that rules adopted by any of the three commissions are not acceptable, the compacts provide a mechanism for a majority of state legislatures to override commission rules. Furthermore, the state maintains the ability to withdraw from any of the compacts.

B. RULE-MAKING AUTHORITY:

The bill provides requisite authority to all impacted state agencies and boards necessary to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 6, 2024, the Health Care Appropriations Subcommittee adopted one amendment, and reported the bill favorably as a committee substitute. The amendment makes changes to several appropriations within the bill, and provided full-time equivalent positions to AHCA and DOH to implement the bill.

This analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to health care; amending s. 381.4018, F.S.; requiring physician licensees to provide to the Department of Health specified information; requiring the department to collect and compile such information in consultation with the Office of Program Policy Analysis and Government Accountability; amending s. 381.4019, F.S.; revising the purpose of the Dental Student Loan Repayment Program; defining the term "free clinic"; including dental hygienists in the program; revising eligibility requirements for the program; specifying limits on award amounts for and participation of dental hygienists under the program; deleting the maximum number of new practitioners who may participate in the program each fiscal year; specifying that dentists and dental hygienists must provide specified documentation; requiring practitioners who receive payments under the program to furnish certain information requested by the Department of Health; requiring the Agency for Health Care Administration to seek federal authority to use specified matching funds for the program; providing for future repeal of the program; transferring, renumbering, and amending s. 1009.65, F.S.; renaming the Medical Education Reimbursement and Loan Repayment

Program as the "Florida Reimbursement Assistance for Medical Education Program"; revising the types of providers who are eligible to participate in the program; revising requirements for the distribution of funds under the program; requiring the Agency for Health Care Administration to seek federal authority to use specified matching funds for the program; creating s. 381.4021, F.S.; requiring the Department of Health to provide to the Governor and the Legislature an annual report on specified student loan repayment programs; providing requirements for the report; requiring the department to contract with an independent third party to develop and conduct a design study for evaluating the effectiveness of specified student loan repayment programs; specifying requirements for the design study; requiring the department to submit the study results to the Governor and the Legislature by dates certain; requiring the department to participate in a certain multistate collaborative for a specified purpose; providing for future repeal of the requirement; creating s. 381.9855, F.S.; requiring the department to implement a health care screening and services grant program for a specified purpose; specifying duties of the department; authorizing nonprofit entities to apply

for grant funds to implement new health care screening, service programs, or mobile clinics or units to expand the program's delivery capabilities; specifying requirements for grant recipients; authorizing the department to adopt rules; requiring the department to create and maintain an Internet-based portal to provide specified information relating to available health care screenings and services and volunteer opportunities; authorizing the department to contract with a third-party vendor to create and maintain the portal; specifying requirements for the portal; requiring the department to coordinate with county health departments for a specified purpose; requiring the department to include a clear and conspicuous link to the portal on the homepage of its website; requiring the department to publicize and encourage the use of the portal and enlist the aid of county health departments for such outreach; amending s. 383.2163, F.S.; expanding the telehealth minority maternity care program from a pilot program to a statewide program; requiring the department to submit to the Governor and the Legislature an annual report; providing requirements for the report; amending s. 383.302, F.S.; providing and revising definitions; creating s. 383.3081, F.S.; providing requirements for

birth centers to be designated as advanced birth centers with respect to operating procedures, staffing, and equipment; requiring an advanced birth center to enter into a written agreement with a blood bank for emergency blood bank services; requiring that a patient who receives an emergency blood transfusion at an advanced birth center be immediately transferred to a hospital for further care; requiring the agency to establish by rule a process for birth centers to be designated as advanced birth centers; amending s. 383.309, F.S.; providing minimum standards for advanced birth centers; authorizing the Agency for Health Care Administration to enforce specified provisions of the Florida Building Code and the Florida Fire Prevention Code for advanced birth centers; amending s. 383.313, F.S.; conforming provisions to changes made by the act; creating s. 383.3131, F.S.; providing requirements for laboratory and surgical services at advanced birth centers; providing conditions for administration of anesthesia; authorizing the intrapartal use of chemical agents; amending s. 383.315, F.S.; requiring advanced birth centers to employ or maintain an agreement with an obstetrician for specified purposes; amending s. 383.316, F.S.; requiring advanced birth centers to

provide for the transport of emergency patients to a hospital; requiring each advanced birth center to enter into a written transfer agreement with a local hospital or an obstetrician for such transfers; requiring birth centers and advanced birth centers to assess and document transportation services and transfer protocols annually; amending s. 383.318, F.S.; providing protocols for postpartum care of clients and infants at advanced birth centers; providing requirements for followup care; amending s. 394.455, F.S.; revising definitions; amending s. 394.457, F.S.; requiring the Department of Children and Families to adopt certain minimum standards for mobile crisis response services; amending s. 394.4598, F.S.; authorizing certain psychiatric nurses to provide opinions to the court for the appointment of guardian advocates; authorizing certain psychiatric nurses to consult with guardian advocates for purposes of obtaining consent for treatment; amending s. 394.4615, F.S.; authorizing psychiatric nurses to make certain determinations related to the release of clinical records; amending s. 394.4625, F.S.; requiring certain treating psychiatric nurses to document specified information in a patient's clinical record within a specified timeframe of his or her

voluntary admission for mental health treatment; requiring clinical psychologists who make determinations of involuntary placement at certain mental health facilities to have specified clinical experience; authorizing certain psychiatric nurses to order emergency treatment for certain patients; amending s. 394.463, F.S.; authorizing certain psychiatric nurses to order emergency treatment of certain patients; requiring a clinical psychologist to have specified clinical experience to approve the release of an involuntary patient at certain mental health facilities; amending s. 394.4655, F.S.; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary outpatient services for mental health treatment; authorizing certain psychiatric nurses to recommend involuntary outpatient services for mental health treatment; providing an exception; authorizing psychiatric nurses to make certain clinical determinations that warrant bringing a patient to a receiving facility for an involuntary examination; amending s. 394.467, F.S.; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary inpatient services for mental health treatment; authorizing certain

psychiatric nurses to recommend involuntary inpatient services for mental health treatment; amending s. 394.4781, F.S.; revising the definition of the term "psychotic or severely emotionally disturbed child"; amending s. 394.4785, F.S.; authorizing psychiatric nurses to admit individuals over a certain age into certain mental health units of a hospital under certain conditions; requiring the agency to seek federal approval for Medicaid coverage and reimbursement authority for mobile crisis response services; requiring the Department of Children and Families to coordinate with the agency to provide specified education to contracted mobile response team services providers; amending s. 394.875, F.S.; authorizing certain psychiatric nurses to prescribe medication to clients of crisis stabilization units; amending s. 395.1055, F.S.; requiring the agency to adopt rules ensuring that hospitals do not accept certain payments and requiring certain hospitals to submit an emergency department diversion plan to the agency for approval before initial licensure or licensure renewal; providing that, beginning on a date certain, such plan must be approved before a license may be issued or renewed; requiring such hospitals to submit specified data to the agency on an annual basis

and update their plans as needed, or as directed by the agency, before each licensure renewal; specifying requirements for the diversion plans; requiring the agency to establish a process for hospitals to share certain information with certain patients' managed care plans; amending s. 395.301, F.S.; requiring a licensed facility to post on its website a consumer-friendly list of standard charges for a minimum number of shoppable health care services; providing definitions; requiring a licensed facility to provide an estimate to a patient or prospective patient and the patient's health insurer within specified timeframes; requiring a licensed facility to establish an internal grievance process for patients to dispute charges; requiring a facility to make available information necessary for initiating a grievance; requiring a facility to respond to a patient grievance within a specified timeframe; requiring licensed a facility to disclose specified information relating to cost sharing obligations to certain persons; providing a penalty; creating s. 395.3011, F.S.; defining the term "extraordinary collection action"; prohibiting certain collection activities by a licensed facility; amending s. 408.051, F.S.; requiring certain hospitals to make available certain data to the agency's Florida

Health Information Exchange program for a specified purpose; authorizing the agency to adopt rules; amending s. 409.909, F.S.; authorizing the agency to allocate specified funds under the Slots for Doctors Program for existing resident positions at hospitals and qualifying institutions if certain conditions are met; requiring hospitals and qualifying institutions that receive certain state funds to report specified data to the agency annually; requiring certain hospitals and qualifying institutions to annually report to the agency specified data; defining the term "sponsoring institution"; requiring such hospitals and qualifying institutions, beginning on a date certain, to produce certain financial records or submit to certain financial audits; providing applicability; providing that hospitals and qualifying institutions that fail to produce such financial records to the agency are no longer eligible to participate in the Statewide Medicaid Residency Program until a certain determination is made by the agency; requiring hospitals and qualifying institutions to request exit surveys of residents upon completion of residency; providing requirements for the exit surveys; creating the Graduate Medical Education Committee within the agency; providing for membership and meetings of the

committee; requiring the committee, beginning on a specified date, to submit to the Governor and the Legislature an annual report detailing specified information; requiring the agency to provide administrative support to assist the committee in the performance of its duties and to provide certain information to the committee; creating s. 409.91256, F.S.; creating the Training, Education, and Clinicals in Health (TEACH) Funding Program for a specified purpose; providing legislative intent; providing definitions; requiring the agency to develop an application process and enter into certain agreements to implement the program; specifying requirements to qualify to receive reimbursements under the program; requiring the agency, in consultation with the Department of Health, to develop, or contract for the development of, specified training for, and to provide assistance to, preceptors; providing for reimbursement under the program; requiring the agency to submit to the Governor and the Legislature an annual report; providing requirements for the report; requiring the agency to contract with an independent third party to develop and conduct a design study for evaluating the impact of the program; specifying requirements for the design study; requiring the agency to begin collecting

data for the study and submit the study results to the Governor and the Legislature by dates certain; authorizing the agency to adopt rules; requiring the agency to seek federal approval to use specified matching funds for the program; providing for future repeal of the program; amending s. 409.967, F.S.; requiring the agency to produce an annual report on patient encounter data under the statewide managed care program; providing requirements for the report; requiring the agency to submit to the Governor and the Legislature the report by a date certain; authorizing the agency to contract with a third-party vendor to produce the report; amending s. 409.973, F.S.; requiring Medicaid managed care plans to continue assisting certain enrollees in scheduling an initial appointment with a primary care provider; requiring such plans to coordinate with hospitals that contact them for a specified purpose; requiring the plans to coordinate with their members and members' primary care providers for such purpose; requiring the agency to seek federal approval necessary to implement an acute hospital care at home program meeting specified criteria; creating s. 456.0145, F.S.; providing a short title; providing definitions; requiring an applicable health care regulatory board, or the

department if there is no board, to issue a license or certification to applicants who meet specified conditions; requiring the department and the board to list on their respective websites jurisdictions that meet the minimum requirements for interstate licensure; authorizing the board or the department, as applicable, to require applicants to pass a specified examination under certain circumstances; creating a presumption that an applicant is qualified for interstate licensure, unless the board or department, as applicable, demonstrates otherwise; requiring the board or the department, as applicable, to provide applicants with a written decision within a specified timeframe; authorizing applicants to appeal certain decisions of a board or the department, as applicable; specifying that applicants granted an interstate license are still subject to the applicable laws and rules in this state and the jurisdiction of the applicable board, or the department if there is no board; providing applicability and construction; requiring the department to submit to the Governor and the Legislature an annual report by a date certain; providing requirements for the report; requiring the boards and the department to adopt rules, as applicable; amending s. 456.073, F.S.; requiring the

Department of Health to report certain investigative information to the data system; amending s. 456.076, F.S.; requiring that monitoring contracts for certain impaired practitioners participating in treatment programs contain specified terms; creating s. 456.4501, F.S.; enacting the Interstate Medical Licensure Compact in this state; providing purposes of the compact; providing that state medical boards of member states retain jurisdiction to impose adverse action against licenses issued under the compact; providing definitions; specifying eligibility requirements for physicians seeking an expedited license under the compact; providing requirements for designation of a state of principal license for purposes of the compact; authorizing the Interstate Medical Licensure Compact Commission to develop certain rules; providing an application and verification process for expedited licensure under the compact; providing for expiration and termination of expedited licenses; authorizing the Interstate Commission to develop certain rules; providing requirements for renewal of expedited licenses; authorizing the Interstate Commission to develop certain rules; providing for the establishment of a database for coordinating licensure data amongst

member states; requiring and authorizing member boards to report specified information to the database; providing for confidentiality of such information; providing construction; authorizing the Interstate Commission to develop certain rules; authorizing member states to conduct joint investigations and share certain materials; providing for disciplinary action of physicians licensed under the compact; creating the Interstate Medical Licensure Compact Commission; providing purpose and authority of the commission; providing for membership and meetings of the commission; providing public meeting and notice requirements; authorizing closed meetings under certain circumstances; providing public record requirements; requiring the commission to establish an executive committee; providing for membership, powers, and duties of the committee; authorizing the commission to establish other committees; specifying powers and duties of the commission; providing for financing of the commission; providing for organization and operation of the commission; providing limited immunity from liability for commissioners and other agents or employees of the commission; authorizing the commission to adopt rules; providing for rulemaking procedures, including public

notice and meeting requirements; providing for judicial review of adopted rules; providing for oversight and enforcement of the compact in member states; requiring courts in member states to take judicial notice of the compact and the commission rules for purposes of certain proceedings; providing that the commission is entitled to receive service of process and has standing in certain proceedings; rendering judgments or orders void as to the commission, the compact, or commission rules under certain circumstances; providing for enforcement of the compact; specifying venue and civil remedies in such proceedings; providing for attorney fees; providing construction; specifying default procedures for member states; providing for dispute resolution between member states; providing for eligibility and procedures for enactment of the compact; providing for amendment to the compact; specifying procedures for withdrawal from and subsequent reinstatement of the compact; authorizing the Interstate Commission to develop certain rules; providing for dissolution of the compact; providing severability and construction; creating s. 456.4502, F.S.; providing that a formal hearing before the Division of Administrative Hearings must be held if there are any disputed issues of

material fact when the licenses of certain physicians and osteopathic physicians are suspended or revoked by this state under the compact; requiring the Department of Health to notify the Division of Administrative Hearings of a petition for a formal hearing within a specified timeframe; requiring the administrative law judge to issue a recommended order; requiring the Board of Medicine or the Board of Osteopathic Medicine, as applicable, to determine and issue final orders in certain cases; providing the department with standing to seek judicial review of any final order of the boards; creating s. 456.4504, F.S.; authorizing the department to adopt rules; specifying that provisions of the Interstate Medical Licensure Compact do not authorize the Department of Health, the Board of Medicine, or the Board of Osteopathic Medicine to collect a fee for expedited licensure, but rather state that fees of that kind are allowable under the compact; amending s. 457.105, F.S.; revising requirements for a person to become licensed to practice acupuncture; amending s. 458.311, F.S.; revising an education and training requirement for physician licensure; exempting certain foreign-trained applicants for physician licensure from the residency requirement; providing certain employment requirements

for such applicants; requiring such applicants to notify the Board of Medicine of any changes in employment within a specified timeframe; repealing s. 458.3124, F.S., relating to restricted licenses of certain experienced foreign-trained physicians; amending s. 458.313; revising requirements for an applicant for licensure by endorsement to practice as a physician; amending s. 458.314, F.S.; authorizing the board to exclude certain foreign medical schools from consideration as an institution that provides medical education that is reasonably comparable to similar accredited institutions in the United States; providing construction; deleting obsolete language; amending s. 458.3145, F.S.; revising criteria for medical faculty certificates; deleting a cap on the maximum number of extended medical faculty certificates that may be issued at specified institutions; amending ss. 458.315 and 459.0076, F.S.; authorizing temporary certificates for practice in areas of critical need to be issued to physician assistants, rather than only to physicians, who meet specified criteria; amending ss. 458.317 and 459.0075, F.S.; specifying who may be considered a graduate assistant physician; creating limited licenses for graduate assistant physicians; specifying criteria a

person must meet to obtain such licensure; requiring the Board of Medicine and the Board of Osteopathic Medicine, respectively, to establish certain requirements by rule; providing for a one-time renewal of such licenses; authorizing limited licensed graduate assistant physicians to provide health care services only under the direct supervision of a physician and pursuant to a written protocol; providing requirements for, and limitations on, such supervision and practice; providing requirements for the supervisory protocols; providing that supervising physicians are liable for any acts or omissions of such graduate assistant physicians acting under their supervision and control; authorizing third-party payors to provide reimbursement for covered services rendered by graduate assistant physicians; authorizing the Board of Medicine and the Board of Osteopathic Medicine, respectively, to adopt rules; amending s. 464.009, F.S.; revising requirements for an applicant for licensure by endorsement to practice by endorsement to practice professional or practical nursing; creating s. 464.0121, F.S.; providing that temporary certificates for practice in areas of critical need may be issued to advanced practice registered nurses who meet specified criteria;

providing restrictions on the issuance of temporary certificates; waiving licensure fees for such applicants under certain circumstances; amending s. 464.0123, F.S.; requiring certain certified nurse midwives, as a condition precedent to providing out-of-hospital intrapartum care, to maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services; requiring that such policy prescribe and require the use of an emergency plan-of-care form; providing requirements for the form; requiring such certified nurse midwives to document specified information on the form if a transfer of care is determined to be necessary; requiring certified nurse midwives to verbally provide the receiving provider with specified information and make himself or herself immediately available for consultation; requiring certified nurse midwives to provide the patient's emergency plan-of-care form, as well as certain patient records, to the receiving provider upon the patient's transfer; requiring the Board of Nursing to adopt certain rules; amending s. 464.019, F.S.; deleting the sunset date of a certain annual report required of the Florida Center for Nursing; amending ss. 465.0075, 467.0125, 468.1705, 468.3065, 478.47, 480.041, and 491.006; revising

licensure requirements to include licensure by endorsement to practice as a pharmacist; midwife; nursing home administrator; radiologist, radiologic technologist, and specialty technologist; electrologist; or psychologist or school psychologist, respectively; repealing ss. 468.213 and 468.358, F.S., relating to licensure by endorsement for occupational therapists and respiratory therapists, respectively; creating s. 458.3129 and 459.074, F.S.; providing that an allopathic physician or an osteopathic physician, respectively, licensed under the compact is deemed to be licensed under ch. 458, F.S., or ch. 459, F.S., as applicable; amending s. 468.1135, F.S.; requiring the Board of Speech-Language Pathology and Audiology to appoint two of its board members to serve as the state's delegates on the compact commission; amending s. 468.1185, F.S.; removing provisions relating to licensure by endorsement and refusal of certification for speech-language pathologists and audiologists; exempting audiologists and speech-language pathologists from licensure requirements who are practicing in this state pursuant to a compact privilege under the compact; amending s. 468.1295, F.S.; authorizing the board to take adverse action against the compact privilege of audiologists and

speech-language pathologists for specified prohibited acts; creating s. 468.1335, F.S.; creating the Practice of Audiology and Speech-language Pathology Interstate Compact; providing purpose, objectives, and definitions; specifying requirements for state participation in the compact and duties of member states; specifying that the compact does not affect an individual's ability to apply for, and a member state's ability to grant, a single-state license pursuant to the laws of that state; providing for recognition of compact privilege in member states; specifying criteria a licensee must meet for compact privilege; providing for the expiration and renewal of compact privilege; specifying that a licensee with compact privilege in a remote state must adhere to the laws and rules of that state; authorizing member states to act on a licensee's compact privilege under certain circumstances; specifying the consequences and parameters of practice for a licensee whose compact privilege has been acted on or whose home state license is encumbered; specifying that a licensee may hold a home state license in only one member state at a time; specifying requirements and procedures for changing a home state license designation; providing for the recognition of the practice of audiology and

speech-language pathology through telehealth in member states; specifying that a licensee must adhere to the laws and rules of the remote state in which he or she provides audiology or speech-language pathology through telehealth; authorizing active duty military personnel and their spouses to keep their home state designation during active duty; specifying how such individual may subsequently change his or her home state license designation; authorizing member states to take adverse actions against licensees and issue subpoenas for hearings and investigations under certain circumstances; providing requirements and procedures for such adverse action; authorizing member states to engage in joint investigations under certain circumstances; providing that a licensee's compact privilege must be deactivated in all member states for the duration of an encumbrance imposed by the licensee's home state; providing for notice to the data system and the licensee's home state of any adverse action taken against a licensee; establishing the Audiology and Speech-language Pathology Interstate Compact Commission; providing for jurisdiction and venue for court proceedings; providing for membership and powers of the commission; specifying powers and duties of the commission's executive committee;

providing for the financing of the commission; providing specified individuals immunity from civil liability under certain circumstances; providing exceptions; requiring the commission to defend the specified individuals in civil actions under certain circumstances; requiring the commission to indemnify and hold harmless specified individuals for any settlement or judgment obtained in such actions under certain circumstances; providing for the development of the data system, reporting procedures, and the exchange of specified information between member states; requiring the commission to notify member states of any adverse action taken against a licensee or applicant for licensure; authorizing member states to designate as confidential information provided to the data system; requiring the commission to remove information from the data system under certain circumstances; providing rulemaking procedures for the commission; providing for member state enforcement of the compact; authorizing the commission to receive notice of process, and have standing to intervene, in certain proceedings; rendering certain judgments and orders void as to the commission, the compact, or commission rules under certain circumstances; providing for defaults and termination of compact

membership; providing procedures for the resolution of certain disputes; providing for commission enforcement of the compact; providing for remedies; providing for implementation of, withdrawal from, and amendment to the compact; specifying that licensees practicing in a remote state under the compact must adhere to the laws and rules of that state; specifying that the compact, commission rules, and commission actions are binding on member states; providing construction; providing for severability; specifying that the provisions of the Physical Therapy Licensure Compact do not authorize the Department of Health or the Board of Physical Therapy to collect a compact privilege fee, but rather state that fees of that kind are allowable under the compact; authorizing the Department of Health or the Board of Speech-Language Pathology and Audiology to collect a compact privilege fee; amending ss. 486.028, 486.031, 486.081, 486.102, 486.107, and 490.006, F.S.; exempting from licensure requirements physical therapists and physical therapist assistants who are practicing in this state pursuant to a compact privilege under the compact; revising licensure requirements to include licensure by endorsement to practice as a physical therapist; creating s. 486.112, F.S.; creating the Physical Therapy Licensure Compact;

providing a purpose and objectives of the compact; providing definitions; specifying requirements for state participation in the compact; authorizing member states to obtain biometric-based information from and conduct criminal background checks on licensees applying for a compact privilege; requiring member states to grant the compact privilege to licensees who meet specified criteria; specifying criteria licensees must meet to exercise the compact privilege under the compact; providing for the expiration of the compact privilege; requiring licensees practicing in a remote state under the compact privilege to comply with the laws and rules of that state; subjecting licensees to the regulatory authority of remote states where they practice under the compact privilege; providing for disciplinary action; specifying circumstances under which licensees are ineligible for a compact privilege; specifying conditions that a licensee must meet to regain his or her compact privilege after an adverse action; specifying locations active duty military personnel and their spouses may use to designate their home state for purposes of the compact; providing that only a home state may impose adverse action against a license issued by that state; authorizing home states to take adverse action based

on investigative information of a remote state, subject to certain requirements; directing member states that use alternative programs in lieu of discipline to require the licensee to agree not to practice in other member states while participating in the program, unless authorized by the member state; authorizing member states to investigate violations by licensees in other member states; authorizing member states to take adverse action against compact privileges issued in their respective states; providing for joint investigations of licensees under the compact; establishing the Physical Therapy Compact Commission; providing for the venue and jurisdiction for court proceedings by or against the commission; providing construction; providing for commission membership, voting, and meetings; authorizing the commission to convene closed, nonpublic meetings under certain circumstances; specifying duties and powers of the commission; providing for membership and duties of the executive board of the commission; providing for financing of the commission; providing for qualified immunity, defense, and indemnification of the commission; requiring the commission to develop and maintain a coordinated database and reporting system for certain information about licensees under the

compact; requiring member states to submit specified information to the system; requiring that information contained in the system be available only to member states; requiring the commission to promptly notify all member states of reported adverse action taken against licensees or applicants for licensure; authorizing member states to designate reported information as exempt from public disclosure; providing for the removal of submitted information from the system under certain circumstances; providing for commission rulemaking; providing construction; providing for state enforcement of the compact; providing for the default and termination of compact membership; providing for appeals and costs; providing procedures for the resolution of certain disputes; providing for enforcement against a defaulting state; providing construction; providing for implementation and administration of the compact and associated rules; providing that compact states that join after initial adoption of the commission's rules are subject to such rules; specifying procedures for compact states to withdraw from the compact; providing construction; providing for amendment of the compact; providing construction and severability; specifying that the provisions of the Physical Therapy Licensure

Compact do not authorize the Department of Health or the Board of Physical Therapy to collect a compact privilege fee, but rather state that fees of that kind are allowable under the compact; amending s. 486.023, F.S.; requiring the Board of Physical Therapy Practice to appoint a person to serve as the state's delegate on the Physical Therapy Compact Commission; amending s. 486.125, F.S.; authorizing the board to take adverse action against the compact privilege of physical therapists and physical therapist assistants for specified prohibited acts; amending s. 624.27, F.S.; revising the definition of the term "health care provider"; amending s. 95.11, F.S.; establishing a 3-year statute of limitations for an action to collect medical debt for services rendered by a health care provider or facility; creating s. 222.26, F.S.; providing additional personal property exemptions from legal process for medical debts resulting from services provided in certain licensed facilities; creating s. 627.446, F.S.; providing a definition; requiring each health insurer to provide an insured with an advanced explanation of benefits after receiving a patient estimate from a facility for scheduled services; providing requirements for the advanced explanation of benefits; amending s. 627.447,

F.S.; prohibiting a health insurer from disclosing specified information relating to discounted cash prices to certain persons; defining the term "discounted cash price"; amending s. 627.6387, F.S.; revising definitions; requiring, rather than authorizing, a health insurer to offer a shared savings incentive program for specified purposes; requiring a health insurer to notify an insured that participation in such program is voluntary and optional; amending ss. 627.6648 and 641.31076, F.S.; providing that a shared savings incentive offered by a health insurer or health maintenance organization constitutes a medical expense for rate development and rate filing purposes; amending s. 766.1115, F.S.; revising the definition of the term "low-income" for purposes of certain government contracts for health care services; amending s. 768.28, F.S.; designating the state delegates and other members or employees of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-Language Pathology Interstate Compact Commission, and the Physical Therapy Compact Commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain

insurance coverage to pay such claims or judgments; amending s. 1002.32, F.S.; requiring developmental research schools to develop programs for a specified purpose; requiring schools to offer technical assistance to any school district seeking to replicate the school's programs; requiring schools, beginning on a date certain, to annually report to the Legislature on the development of such programs and the results, when available; amending s. 1004.015, F.S.; requiring the Commission for Independent Education and the Independent Colleges and Universities of Florida to annually report specified data for each medical school graduate; amending s. 1009.8962, F.S.; revising the definition of the term "institution" for purposes of the Linking Industry to Nursing Education (LINE) Fund; requiring the Board of Governors and the Department of Education to submit to the Governor and the Legislature a specified report; amending ss. 486.025, 486.0715, and 486.1065, F.S.; conforming cross-references; amending ss. 395.602, 458.316, 458.3165, 468.209, 468.511, 475.01, 475.611, 517.191, and 787.061, F.S.; conforming provisions to changes made by the act; providing appropriations; providing a directive to the department; providing effective dates.

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

Section 1. Paragraph (f) of subsection (3) of section 381.4018, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

381.4018 Physician workforce assessment and development.—

(3) GENERAL FUNCTIONS.—The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the department shall:

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas, in otherwise medically underserved areas, or in rural areas. Strategies shall also consider the use of state programs, such as the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program pursuant to s. 381.402 ~~s. 1009.65~~, which provide for education loan repayment or loan forgiveness and

provide monetary incentives for physicians to relocate to underserved areas of the state.

The department may adopt rules to implement this subsection, including rules that establish guidelines to implement the federal Conrad 30 Waiver Program created under s. 214(l) of the Immigration and Nationality Act.

(5) DATA COLLECTION.—To facilitate ongoing monitoring and analyses of the state's graduate medical education system, the department shall require physician licensees to provide the following information:

(a) For each licensed resident and physician, the state in which he or she attended medical school, the state in which he or she was trained in graduate medical education programs, his or her graduate medical education specialty, and the beginning date and completion date of his or her graduate medical education training.

(b) For each licensed resident and physician who received graduate medical education in Florida, the name of the medical school, accredited program, and sponsoring institution.

The department shall collect and compile the information required by this subsection in consultation with the Office of Program Policy Analysis and Government Accountability.

Section 2. Section 381.4019, Florida Statutes, is amended

to read:

381.4019 Dental Student Loan Repayment Program.—The Dental Student Loan Repayment Program is established to support the state Medicaid program and promote access to dental care by supporting qualified dentists and dental hygienists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas.

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

(a) "Dental health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

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

(c) "Free clinic" means a provider that meets the description of a clinic specified in s. 766.1115(3)(d)14.

(d) ~~(c)~~ "Loan program" means the Dental Student Loan Repayment Program.

(e) ~~(d)~~ "Medically underserved area" means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients.

(f) ~~(e)~~ "Public health program" means a county health department, the Children's Medical Services program, a federally

funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a dental student loan repayment program to benefit Florida-licensed dentists and dental hygienists who:

(a) Demonstrate, as required by department rule, active employment in a public health program or private practice that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area.

(b) Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or a medically underserved area or through another volunteer program operated by the state pursuant to part IV of chapter 110. In order to meet the requirements of this paragraph, the volunteer hours must be verifiable in a manner determined by the department.

(3) The department shall award funds from the loan program to repay the student loans of a dentist or dental hygienist who meets the requirements of subsection (2).

(a) An award shall be 20 percent of a dentist's or dental hygienist's principal loan amount at the time he or she applies for the program but may not exceed $50,000 per year per eligible dentist or $7,500 per year per eligible dental hygienist.

(b) Only loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses may be covered.

(c) All repayments are contingent upon continued proof of eligibility and must be made directly to the holder of the loan. The state bears no responsibility for the collection of any interest charges or other remaining balances.

(d) A dentist or dental hygienist may receive funds under the loan program for at least 1 year, up to a maximum of 5 years.

~~(e) The department shall limit the number of new dentists participating in the loan program to not more than 10 per fiscal year.~~

(4) A dentist or dental hygienist is not ~~is no longer~~ eligible to receive funds under the loan program if the dentist or dental hygienist:

(a) Is no longer employed by a public health program or private practice that meets the requirements of subsection (2) or does not verify, in a manner determined by the department, that he or she has volunteered his or her dental services for the required number of hours.

(b) Ceases to participate in the Florida Medicaid program.

(c) Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of s. 466.028.

(5) A dentist or dental hygienist who receives payment

under the program shall furnish information requested by the department for the purpose of the department's duties under s. 381.4021.

(6) ~~(5)~~ The department shall adopt rules to administer the loan program.

(7) ~~(6)~~ Implementation of the loan program is subject to legislative appropriation.

(8) The Agency for Health Care Administration shall seek federal authority to use Title XIX matching funds for this program.

(9) This section is repealed on July 1, 2034.

Section 3. Section 1009.65, Florida Statutes, is amended, transferred, and renumbered as section 381.402, Florida Statutes, and amended, to read:

381.402 ~~1009.65~~ Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program.—

(1) To support the state Medicaid program and to encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, there is established the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program. The function of the program is to make payments that offset loans and educational expenses incurred by students for studies leading to a medical or nursing degree, medical or nursing licensure, or advanced practice registered nurse licensure or physician

assistant licensure.

(2) The following licensed or certified health care practitioners ~~professionals~~ are eligible to participate in the ~~this~~ program:

(a) Medical doctors and doctors of osteopathic medicine practicing in ~~with~~ primary care specialties.~~, doctors of osteopathic medicine with primary care specialties~~

(b) Advanced practice registered nurses practicing in primary care specialties~~, physician assistants, licensed practical nurses and registered nurses, and advanced practice registered nurses with primary care specialties such as certified nurse midwives~~.

(c) Physician assistants.

(d) Mental health professionals, including licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists.

(e) Licensed practical nurses and registered nurses.

Primary care ~~medical~~ specialties for physicians include obstetrics, gynecology, general and family practice, geriatrics, internal medicine, pediatrics, psychiatry, and other specialties that ~~which~~ may be identified by the Department of Health. Primary care specialties for advanced practice registered nurses include family practice, general pediatrics, general internal

medicine, midwifery, and psychiatric nursing.

(3) From the funds available, the Department of Health shall make payments as follows:

(a)~~1.~~ For a 4-year period of continued proof of practice in a setting specified in paragraph (b), up to $150,000 for physicians, up to $90,000 for advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123, up to $75,000 for advanced practice registered nurses, physician assistants, and mental health professionals, and up to $45,000 ~~up to $4,000 per year~~ for licensed practical nurses and registered nurses. Each practitioner is eligible to receive an award for only one 4-year period of continued proof of practice. At the end of each year that a practitioner participates in the program, the department shall award 25 percent of a practitioner's principal loan amount at the time he or she applied for the program~~, up to $10,000 per year for advanced practice registered nurses and physician assistants, and up to $20,000 per year for physicians~~. Penalties for noncompliance are ~~shall be~~ the same as those in the National Health Services Corps Loan Repayment Program. Educational expenses include costs for tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the Department of Health.

(b)~~2.~~ All payments are contingent on continued proof of:

1.a. Primary care practice in a rural hospital as ~~an area~~

defined in s. 395.602(2)(b)~~,~~ or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement; or

b. For practitioners other than physicians and advanced practice registered nurses, practice in other settings, including, but not limited to, a nursing home facility as defined in s. 400.021, a home health agency as defined in s. 400.462, or an intermediate care facility for the developmentally disabled as defined in s. 400.960. Any such setting must be located in, or serve residents or patients in, an underserved area designated by the Department of Health and must provide services to Medicaid patients.

2. Providing 25 hours annually of volunteer primary care services in a free clinic as specified in s. 766.1115(3)(d)14. or through another volunteer program operated by the state pursuant to part IV of chapter 110. In order to meet the requirements of this subparagraph, the volunteer hours must be verifiable in a manner determined by the department.

(c) Correctional facilities, state hospitals, and other state institutions that employ medical personnel must ~~shall~~ be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

~~(b) Advanced practice registered nurses registered to~~

~~engage in autonomous practice under s. 464.0123 and practicing in the primary care specialties of family medicine, general pediatrics, general internal medicine, or midwifery. From the funds available, the Department of Health shall make payments of up to $15,000 per year to advanced practice registered nurses registered under s. 464.0123 who demonstrate, as required by department rule, active employment providing primary care services in a public health program, an independent practice, or a group practice that serves Medicaid recipients and other low-income patients and that is located in a primary care health professional shortage area. Only loans to pay the costs of tuition, books, medical equipment and supplies, uniforms, and living expenses may be covered. For the purposes of this paragraph:~~

~~1. "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.~~

~~2. "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or any other publicly funded or nonprofit health care program designated by the department.~~

(4) ~~(2)~~ The Department of Health may use funds appropriated for the ~~Medical Education Reimbursement and Loan Repayment~~ program as matching funds for federal loan repayment programs such as the National Health Service Corps State Loan Repayment Program.

(5) A health care practitioner who receives payment under the program shall furnish information requested by the department for the purpose of the department's duties under s. 381.4021.

(6) ~~(3)~~ The Department of Health may adopt any rules necessary for the administration of the ~~Medical Education Reimbursement and Loan Repayment~~ program. The department may also solicit technical advice regarding conduct of the program from the Department of Education and Florida universities and Florida College System institutions. The Department of Health shall submit a budget request for an amount sufficient to fund medical education reimbursement, loan repayments, and program administration.

(7) The Agency for Health Care Administration shall seek federal authority to use Title XIX matching funds for this program.

(8) This section is repealed on July 1, 2034.

Section 4. Section 381.4021, Florida Statutes, is created to read:

381.4021 Student loan repayment programs reporting.—

(1) Beginning July 1, 2024, the department shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual report for the student loan repayment programs established in ss. 381.4019 and 381.402, which, at a minimum, details all of the following:

(a) The number of applicants for loan repayment.

(b) The number of loan payments made under each program.

(c) The amounts for each loan payment made.

(d) The type of practitioner to whom each loan payment was made.

(e) The number of loan payments each practitioner has received under either program.

(f) The practice setting in which each practitioner who received a loan payment practices.

(2)(a) The department shall contract with an independent third party to develop and conduct a design study to evaluate the impact of the student loan repayment programs established in ss. 381.4019 and 381.402, including, but not limited to, the effectiveness of the programs in recruiting and retaining health care professionals in geographic and practice areas experiencing shortages. The department shall begin collecting data for the study by January 1, 2025, and shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of the study by January 1, 2030.

(b) The department shall participate in a provider

retention and information system management multistate collaborative that collects data to measure outcomes of education debt support-for-service programs.

(3) This section is repealed on July 1, 2034.

Section 5. Section 381.9855, Florida Statutes, is created to read:

381.9855 Health care screening and services grant program; portal.—

(1)(a) The Department of Health shall implement a health care screening and services grant program. The purpose of the program is to expand access to no-cost health care screenings or services for the general public facilitated by nonprofit entities. The department shall do all of the following:

1. Publicize the availability of funds and enlist the aid of county health departments for outreach to potential applicants at the local level.

2. Establish an application process for submitting a grant proposal and eligibility criteria for applicants.

3. Develop guidelines a grant recipient must follow for the expenditure of grant funds and uniform data reporting requirements for the purpose of evaluating the performance of grant recipients.

(b) A nonprofit entity may apply for grant funds in order to implement a new health care screening or service program that the entity has not previously implemented.

(c) A nonprofit entity that has previously implemented a specific health care screening or services program at one or more specific locations may apply for grant funds in order to provide the same or similar screenings or services at a new location or through a mobile health clinic or mobile unit in order to expand the program's delivery capabilities.

(d) An entity that receives a grant under this section must:

1. Follow Department of Health guidelines for reporting on expenditure of grant funds and measures to evaluate the effectiveness of the entity's health care screening or services program.

2. Publicize to the general public and encourage the use of the health care screening portal created under subsection (2).

(e) The Department of Health may adopt rules for the implementation of this subsection.

(2)(a) The Department of Health shall create and maintain an Internet-based portal to direct the general public to events, organizations, and venues in this state from which health screenings or services may be obtained at no cost or at a reduced cost and for the purpose of directing a licensed health care practitioner to opportunities for volunteering his or her services to conduct, administer, or facilitate such health screenings or services. The department may contract for the

creation or maintenance of the portal with a third-party vendor.

(b) The portal must be easily accessible by the public, not require a sign up or login, and include the ability for a member of the public to enter his or her address and obtain localized and current data on opportunities for screenings and services and volunteer opportunities for health care practitioners. The portal must include, but is not limited to, all statutorily created screening programs that are funded and operational under the department's authority. The department shall coordinate with county health departments so that the portal includes information on such health screenings and services provided by county health departments or by nonprofit entities in partnership with county health departments.

(c) The department shall include a clear and conspicuous link to the portal on the homepage of its website. The department shall publicize the portal to, and encourage the use of the portal by, the general public and shall enlist the aid of county health departments for such outreach.

Section 6. Section 383.2163, Florida Statutes, is amended to read:

383.2163 Telehealth minority maternity care program. ~~pilot programs.—By July 1, 2022~~, The department shall establish a statewide telehealth minority maternity care ~~pilot~~ program that ~~in Duval County and Orange County which~~ uses telehealth to expand the capacity for positive maternal health outcomes in

racial and ethnic minority populations. The department shall direct and assist ~~the~~ county health departments ~~in Duval County and Orange County~~ to implement the program ~~programs~~.

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

(a) "Department" means the Department of Health.

(b) "Eligible pregnant woman" means a pregnant woman who is receiving, or is eligible to receive, maternal or infant care services from the department under chapter 381 or this chapter.

(c) "Health care practitioner" has the same meaning as in s. 456.001.

(d) "Health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(e) "Indigenous population" means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act, as that definition existed on the effective date of this act.

(f) "Maternal mortality" means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) "Medically underserved population" means the

population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health care services or a population group designated by the United States Secretary of Health and Human Services as having a shortage of such services.

(h) "Perinatal professionals" means doulas, personnel from Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy.

(j) "Severe maternal morbidity" means an unexpected outcome caused by a woman's labor and delivery which results in significant short-term or long-term consequences to the woman's health.

(k) "Technology-enabled collaborative learning and capacity building model" means a distance health care education model that connects health care professionals, particularly specialists, with other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(2) PURPOSE.—The purpose of the program ~~pilot programs~~ is

to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.

4. Medically underserved populations.

5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage, infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The program ~~pilot programs~~ shall adopt the use of telehealth or coordinate with prenatal home visiting programs to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start's coordinated intake and referral program to offer families prenatal home visiting services.

(b) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.

2. Transportation services or information on how to access such services.

3. Nutrition counseling.

4. Access to healthy foods.

5. Lactation support.

6. Lead abatement and other efforts to improve air and water quality.

7. Child care options.

8. Car seat installation and training.

9. Wellness and stress management programs.

10. Coordination across safety net and social support services and programs.

(c) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods.

(d) For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers.

(e) Tools for prenatal women to conduct key components of

maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.

2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary.

(4) TRAINING.—The program ~~pilot programs~~ shall provide training to participating health care practitioners and other perinatal professionals on all of the following:

(a) Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers to accessing adequate and competent maternity care.

(b) The use of remote patient monitoring tools for pregnancy-related complications.

(c) How to screen for social determinants of health risks in the prenatal and postpartum periods, such as inadequate housing, lack of access to nutritional foods, environmental

risks, transportation barriers, and lack of continuity of care.

(d) Best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders.

(e) Information collection, recording, and evaluation activities to:

1. Study the impact of the ~~pilot~~ program;

2. Ensure access to and the quality of care;

3. Evaluate patient outcomes as a result of the ~~pilot~~ program;

4. Measure patient experience; and

5. Identify best practices for the future expansion of the ~~pilot~~ program.

(5) REPORT.—By October 31, 2025, and each October 31 thereafter, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a program report that includes, at a minimum, all of the following for the previous fiscal year:

(a) The total number of clients served and the demographic information for the population served, including race, ethnicity, age, education level, and geographic location.

(b) The total number of screenings performed, by type.

(c) The number of participants identified as having experienced pregnancy-related complications, the number of participants who received treatments for such complications, and

the final outcome of the pregnancy for such participants.

(d) The number of referrals made to the Healthy Start program or other prenatal home visiting programs and the number of participants who subsequently received services from such programs.

(e) The number of referrals made to doulas and other perinatal professionals and the number of participants who subsequently received services from doulas and other perinatal professionals.

(f) The number and types of devices given to participants to conduct maternal wellness checks.

(g) The average length of participation by program participants.

(h) Composite results of a participant survey that measures the participants' experience with the program.

(i) The total number of health care practitioners trained, by provider type and specialty.

(j) The results of a survey of the health care practitioners trained under the program. The survey must address the quality and impact of the training provided, the health care practitioners' experiences using remote patient monitoring tools, the best practices provided in the training, and any suggestions for improvements.

(k) Aggregate data on the maternal and infant health outcomes of program participants.

(1) For the initial report, all available quantifiable data related to the telehealth minority maternity care pilot programs.

(6)~~(5)~~ FUNDING.~~—The pilot programs shall be funded using funds appropriated by the Legislature for the Closing the Gap grant program.~~ The department's Division of Community Health Promotion and Office of Minority Health and Health Equity shall ~~also~~ work in partnership to apply for federal funds that are available to assist the department in accomplishing the program's purpose and successfully implementing the program ~~pilot programs~~.

(7)~~(6)~~ RULES.—The department may adopt rules to implement this section.

Section 7. Subsections (1) through (8), (9), and (10) of section 383.302, Florida Statutes, are renumbered as subsections (2) through (9), (11), and (12), respectively, present subsection (4) is amended, and new subsections (1) and (10) are added to that section, to read:

383.302 Definitions of terms used in ss. 383.30-383.332.—As used in ss. 383.30-383.332, the term:

(1) "Advanced birth center" means a licensed birth center designated as an advanced birth center which may perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the beginning of

the 37th week of gestation through the end of the 41st week of gestation.

(5)~~(4)~~ "Consultant" means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center or an advanced birth center and who either:

(a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology;~~,~~ or

(b) Has hospital obstetrical privileges.

(10) "Medical director" means a person who holds an active unrestricted license as a physician under chapter 458 or chapter 459.

Section 8. Section 383.3081, Florida Statutes, is created to read:

383.3081 Advanced birth center designation.—

(1) To be designated as an advanced birth center, a birth center must, in addition to maintaining compliance with all of the requirements under ss. 383.30-383.332 applicable to birth centers and advanced birth centers, meet all of the following criteria:

(a) Be operated and staffed 24 hours per day, 7 days per week.

(b) Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified

obstetrician and one of whom must be a board-certified anesthesiologist.

(c) Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.

(d) Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.

(e) Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions. If a patient admitted to an advanced birth center receives an emergency blood transfusion at the center, the patient must immediately thereafter be transferred to a hospital for further care.

(f) Meet all standards adopted by rule for birth centers, unless specified otherwise, and advanced birth centers pursuant to s. 383.309.

(g) Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.

(h) Qualify for, enter into, and maintain a Medicaid provider agreement with the agency pursuant to s. 409.907 and provide services to Medicaid recipients according to the terms of the provider agreement.

(2) The agency shall establish by rule a process for

designating a birth center that meets the requirements of this section as an advanced birth center.

Section 9. Subsection (2) of section 383.309, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section, to read:

383.309 Minimum standards for birth centers and advanced birth centers; rules and enforcement.—

(2) The standards adopted by rule for designating a birth center as an advanced birth center must, at a minimum, be equivalent to the minimum standards adopted for ambulatory surgical centers pursuant to s. 395.1055 and must include standards for quality of care, blood transfusions, and sanitary conditions for food handling and food service.

Section 10. Section 383.313, Florida Statutes, is amended to read:

383.313 Birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center must obtain and continuously maintain certification by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder in order to perform laboratory tests specified by rule of the agency, and which are appropriate to meet the needs of the patient.

(2) SURGICAL SERVICES.—Except for advanced birth centers authorized to provide surgical services under s. 383.3131, only those surgical procedures that are ~~shall be limited to those~~ normally performed during uncomplicated childbirths, such as episiotomies and repairs, may be performed at a birth center. ~~and shall not include~~ Operative obstetrics or caesarean sections may not be performed at a birth center.

(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIA.—General and conduction anesthesia may not be administered at a birth center. Systemic analgesia may be administered, and local anesthesia for pudendal block and episiotomy repair may be performed if procedures are outlined by the clinical staff and performed by personnel who have the ~~with~~ statutory authority to do so.

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.—Labor may not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor unless prescribed by personnel who have the ~~with~~ statutory authority to do so and unless in connection with and before ~~prior to~~ emergency transport.

Section 11. Section 383.3131, Florida Statutes, is created to read:

383.3131 Advanced birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—An advanced birth center shall

have a clinical laboratory on site. The clinical laboratory must, at a minimum, be capable of providing laboratory testing for hematology, metabolic screening, liver function, and coagulation studies. An advanced birth center may collect specimens for those tests that are requested under protocol. An advanced birth center may perform laboratory tests as defined by rule of the agency. Laboratories located in advanced birth centers must be appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

(2) SURGICAL SERVICES.—In addition to surgical procedures authorized under s. 383.313(2), surgical procedures for low-risk cesarean deliveries and surgical management of immediate complications may also be performed at an advanced birth center. Postpartum sterilization may be performed before discharge of the patient who has given birth during that admission. Circumcisions may be performed before discharge of the newborn infant.

(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIA.—General, conduction, and local anesthesia may be administered at an advanced birth center if administered by personnel who have the statutory authority to do so. All general anesthesia must be administered by an anesthesiologist or a certified registered nurse anesthetist in accordance with s. 464.012. When general

anesthesia is administered, a physician or a certified registered nurse anesthetist must be present in the advanced birth center during the anesthesia and postanesthesia recovery period until the patient is fully alert. Each advanced birth center shall comply with s. 395.0191(2)(b).

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.—Labor may be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor at an advanced birth center if prescribed by personnel who have the statutory authority to do so. Labor may be electively induced beginning at the 39th week of gestation for a patient with a documented Bishop score of 8 or greater.

Section 12. Subsection (3) is added to section 383.315, Florida Statutes, to read:

383.315 Agreements with consultants for advice or services; maintenance.—

(3) An advanced birth center shall employ or maintain an agreement with an obstetrician who must be present in the center at all times during which a patient is in active labor in the center to attend deliveries, available to respond to emergencies, and, when necessary, available to perform cesarean deliveries.

Section 13. Section 383.316, Florida Statutes, is amended to read:

383.316 Transfer and transport of clients to hospitals.—

(1) If unforeseen complications arise during labor, delivery, or postpartum recovery, the client must ~~shall~~ be transferred to a hospital.

(2) Each birth center ~~licensed facility~~ shall make arrangements with a local ambulance service licensed under chapter 401 for the transport of emergency patients to a hospital. Such arrangements must ~~shall~~ be documented in the center's policy and procedures manual ~~of the facility~~ if the birth center does not own or operate a licensed ambulance. The policy and procedures manual ~~shall~~ also must contain specific protocols for the transfer of any patient to a licensed hospital.

(3) Each advanced birth center shall enter into a written transfer agreement with a local hospital licensed under chapter 395 for the transfer and admission of emergency patients to the hospital or a written agreement with an obstetrician who has hospital privileges to provide coverage at all times and who has agreed to accept the transfer of the advanced birth center's patients.

(4) ~~(3)~~ A birth center ~~licensed facility~~ shall identify neonatal-specific transportation services, including ground and air ambulances; list their particular qualifications; and have the telephone numbers for access to these services clearly listed and immediately available.

(5) ~~(4)~~ The birth center shall assess and document ~~Annual~~

~~assessments of~~ the transportation services and transfer protocols annually ~~shall be made and documented~~.

Section 14. Subsections (2) and (3) of section 383.318, Florida Statutes, are renumbered as subsections (3) and (4), respectively, subsection (1) is amended, and a new subsection (2) is added to that section, to read:

383.318 Postpartum care for birth center and advanced birth center clients and infants.—

(1) Except at an advanced birth center that must adhere to the requirements of subsection (2), a mother and her infant must ~~shall~~ be dismissed from a ~~the~~ birth center within 24 hours after the birth of the infant, except in unusual circumstances as defined by rule of the agency. If a mother or an infant is retained at the birth center for more than 24 hours after the birth, a report must ~~shall~~ be filed with the agency within 48 hours after ~~of~~ the birth and must describe ~~describing~~ the circumstances and the reasons for the decision.

(2)(a) A mother and her infant must be dismissed from an advanced birth center within 48 hours after a vaginal delivery or within 72 hours after a delivery by cesarean section, except in unusual circumstances as defined by rule of the agency.

(b) If a mother or an infant is retained at the advanced birth center for more than the timeframes set forth in paragraph (a), a report must be filed with the agency within 48 hours after the scheduled discharge time and must describe the

circumstances and the reasons for the decision.

Section 15. Subsections (5), (31), and (36) of section 394.455, Florida Statutes, are amended to read:

394.455 Definitions.—As used in this part, the term:

(5) "Clinical psychologist" means a person licensed to practice psychology under chapter 490 ~~a psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure,~~ or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.

(31) "Mobile crisis response service" or "mobile response team" means a nonresidential mental and behavioral health crisis service available 24 hours per day, 7 days per week which provides immediate intensive assessments and interventions, including screening for admission into a mental health receiving facility, an addictions receiving facility, or a detoxification facility, for the purpose of identifying appropriate treatment services.

(36) "Psychiatric nurse" means an advanced practice registered nurse licensed under s. 464.012 who has a master's or doctoral degree in psychiatric nursing and~~,~~ holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 1 year ~~2 years~~ of post-master's

clinical experience under the supervision of a physician.

Section 16. Paragraph (c) of subsection (5) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(5) RULES.—

(c) The department shall adopt rules establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service. Minimum standards for mobile crisis response services must:

1. Include child, adolescent, and young adult mobile response teams established under s. 394.495(7) and ensure coverage of all counties by these specified teams.

2. Create a structure for general mobile response teams which focuses on emergency room diversion and the reduction of involuntary commitment under this chapter. The structure must require, but need not be limited to, the following:

a. Triage and rapid crisis intervention within 60 minutes.

b. Provision of and referral to evidence-based services that are responsive to the needs of the individual and the individual's family.

c. Screening, assessment, early identification, and care coordination.

d. Followup at 90 and 180 days to gather outcome data on a mobile crisis response encounter to determine efficacy of the mobile crisis response service.

Section 17. Subsections (1) and (3) of section 394.4598, Florida Statutes, are amended to read:

394.4598 Guardian advocate.—

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and had a guardian with the authority to consent to mental health treatment appointed, the court must ~~it shall~~ appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court must ~~shall~~ appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding must ~~shall~~ be recorded, either electronically or stenographically, and testimony must ~~shall~~ be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the

patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council shall not be appointed. A person ~~who is~~ appointed as a guardian advocate must agree to the appointment.

(3) A facility requesting appointment of a guardian advocate must, before ~~prior to~~ the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.

Section 18. Subsection (11) of section 394.4615, Florida

Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(11) Patients must ~~shall~~ have reasonable access to their clinical records, unless such access is determined by the patient's physician or the patient's psychiatric nurse to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction must ~~shall~~ be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction must ~~shall~~ be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record expires ~~shall expire~~ after 7 days but may be renewed, after review, for subsequent 7-day periods.

Section 19. Paragraph (f) of subsection (1) and subsection (5) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(f) Within 24 hours after admission of a voluntary patient, the treating ~~admitting~~ physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility must ~~shall~~ either

discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(5) TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient must ~~shall~~ be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, if it is determined that such treatment is necessary for the safety of the patient or others.

Section 20. Paragraph (f) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

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

(f) A patient must ~~shall~~ be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist if the physician or psychiatric nurse determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. The release may be approved through telehealth.

Section 21. Paragraphs (a) and (b) of subsection (3), paragraph (b) of subsection (7), and paragraph (a) of subsection (8) of section 394.4655, Florida Statutes, are amended to read:

394.4655 Involuntary outpatient services.—

(3) INVOLUNTARY OUTPATIENT SERVICES.—

(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, a clinical psychologist, or by a psychiatric nurse. Any second

opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate that authorizes the facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.

2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary

outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.

(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a

psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, a clinical psychologist, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.

(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.—

(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court must ~~shall~~ issue an order for involuntary outpatient services. The court order must ~~shall~~ be

for a period of up to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.

2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of

the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).

3. If, in the clinical judgment of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician or psychiatric nurse, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order must ~~shall~~ remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the

patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).

(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.—

(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider must ~~shall~~, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.

2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.

3. A certificate must ~~shall~~ be attached to the petition which includes a statement from the person's physician or clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment.

4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the

petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.

Section 22. Subsection (2) of section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary inpatient placement.—

(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, if the administrator certifies that a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in

diagnosis and treatment of mental illness, a clinical psychologist, or ~~by~~ a psychiatric nurse. Any opinion authorized in this subsection may be conducted through a face-to-face examination, in person, or by electronic means. Such recommendation must ~~shall~~ be entered on a petition for involuntary inpatient placement certificate that authorizes the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

Section 23. Subsection (1) of section 394.4781, Florida Statutes, is amended to read:

394.4781 Residential care for psychotic and emotionally disturbed children.—

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

(a) ~~(b)~~ "Department" means the Department of Children and Families.

(b) ~~(a)~~ "Psychotic or severely emotionally disturbed child" means a child so diagnosed by a psychiatrist or a clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology, who must have ~~who has~~ specialty training and experience with children. Such a severely emotionally disturbed child or psychotic child shall be considered by this diagnosis to benefit by and require residential care as contemplated by this section.

Section 24. Subsection (2) of section 394.4785, Florida Statutes, is amended to read:

394.4785 Children and adolescents; admission and placement in mental facilities.—

(2) A person under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 may not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a person 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician or psychiatric nurse documents in the case record that such placement is medically indicated or for reasons of safety. Such placement must ~~shall~~ be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record.

Section 25. Effective upon this act becoming a law, the Agency for Health Care Administration shall seek federal approval for coverage and reimbursement authority for mobile crisis response services pursuant to 42 U.S.C. s. 1396w-6. The Department of Children and Families must coordinate with the Agency for Health Care Administration to educate contracted providers of child, adolescent, and young adult mobile response team services on the process to enroll as a Medicaid provider, encourage and incentivize enrollment as a Medicaid provider, and reduce barriers to maximizing federal reimbursement for community-based mobile crisis response services.

Section 26. Paragraph (a) of subsection (1) of section

394.875, Florida Statutes, is amended to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician, ~~or~~ psychiatrist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds.

Section 27. Paragraphs (i) and (j) are added to subsection (1) of section 395.1055, Florida Statutes, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(i) A hospital does not accept any payment from a medical

school in exchange for, or directly or indirectly related to, allowing students from the medical school to obtain clinical hours or instruction at that hospital.

(j) Each hospital with an emergency department, including a hospital-based off-campus emergency department, submits to the agency for approval a plan for assisting a patient with gaining access to appropriate care settings when the patient either presents at the emergency department with nonemergent health care needs or indicates, when receiving triage or treatment at the hospital, that the patient lacks regular access to primary care, in order to divert such patient from presenting at the emergency department for future nonemergent care. Effective July 1, 2025, such emergency department diversion plan must be approved by the agency before the hospital may receive initial licensure or licensure renewal occurring after that date. A hospital with an approved emergency department diversion plan must submit data to the agency demonstrating the effectiveness of the hospital's plan on an annual basis and must update the plan as necessary, or as directed by the agency, before each licensure renewal. An emergency department diversion plan must include at least one of the following:

1. A partnership agreement with one or more nearby federally qualified health centers or other primary care settings. The goals of such partnership agreement must include, but need not be limited to, identifying patients who present at

the emergency department for nonemergent care, care that would be best provided in a primary care setting, or emergency care that could potentially have been avoided through the regular provision of primary care; and establishing a relationship between the patient and the federally qualified health center or other primary care setting so that the patient develops a medical home at such setting for nonemergent and preventative health care services.

2. The establishment, construction, and operation of a hospital-owned urgent care center adjacent to the hospital emergency department location or an agreement with an urgent care center within 3 miles of the emergency department if located in an urban area as defined in s. 189.041(1)(b) and within 10 miles of the emergency department if located in a rural community as defined in s. 288.0656(2). Under the hospital's emergency department diversion plan, and as appropriate for the patients' needs, the hospital shall seek to divert to the urgent care center those patients who present at the emergency department needing nonemergent health care services and subsequently assist the patient in obtaining primary care.

For such patients who are enrolled in the Medicaid program and are members of a Medicaid managed care plan, the hospital's emergency department diversion plan must include outreach to the

patients' Medicaid managed care plan and coordination with the managed care plan for establishing a relationship between the patient and a primary care setting as appropriate for the patient, which may include a federally qualified health center or other primary care setting with which the hospital has a partnership agreement. For such Medicaid enrollee, the agency shall establish a process for hospitals to share updated contact information for such patients, if in the hospital's possession, with the patient's managed care plan.

Section 28. Paragraphs (b), (c), and (d) of subsection (1) of section 395.301, Florida Statutes, are redesignated as paragraphs (c), (d), and (e), respectively, subsection (6) is renumbered as subsection (8), present paragraph (b) of subsection (1) is amended, a new paragraph (b) is added to subsection (1), and new subsections (6) and (7) are added to that section, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as

state facilities are exempt from this subsection.

(b) Each licensed facility shall post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services. If a facility provides fewer than 300 distinct shoppable health care services, it shall make available on its website the standard charges for each service it provides. As used in this paragraph, the term:

1. "Shoppable health care service" means a service that can be scheduled by a healthcare consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e) and any services defined in regulations or guidance issued by the United States Department of Health and Human Services.

2. "Standard charge" has the same meaning as that term is defined in regulations or guidance issued by the United States Department of Health and Human Services for purposes of hospital price transparency.

(c)~~(b)~~1. ~~Upon request, and~~ Before providing any nonemergency medical services, each licensed facility shall provide in writing or by electronic means a good faith estimate of reasonably anticipated charges by the facility for the treatment of a ~~the~~ patient's or prospective patient's specific condition. Such estimate must be provided to the patient or prospective patient upon scheduling a medical service. The facility ~~must provide the estimate to the patient or prospective~~

~~patient within 7 business days after the receipt of the request~~ ~~and~~ is not required to adjust the estimate for any potential insurance coverage. The facility must provide the estimate to the patient's health insurer, as defined in s. 627.446(1), and the patient at least 3 business days before a service is to be provided, but no later than 1 business day after the service is scheduled or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after the service is scheduled. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer ~~or health maintenance organization~~ for additional information concerning cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the

estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. ~~Upon request,~~ The facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

~~6. The facility shall take action to educate the public that such estimates are available upon request.~~

6.~~7.~~ Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient or prospective patient and the health insurer. The total fine per patient estimate may not exceed $10,000.

~~The provision of an estimate does not preclude the actual charges from exceeding the estimate.~~

(6) Each facility shall establish an internal process for reviewing and responding to grievances from patients. Such process must allow patients to dispute charges that appear on the patient's itemized statement or bill. The facility shall prominently post on its website and indicate in bold print on

each itemized statement or bill the instructions for initiating a grievance and the direct contact information required to initiate the grievance process. The facility must provide an initial response to a patient grievance within 7 business days after the patient formally files a grievance disputing all or a portion of an itemized statement or bill.

(7) Each licensed facility shall disclose to a patient, prospective patient, or a patient's legal guardian whether a cost-sharing obligation for a particular covered health care service or item exceeds the charge that applies to an individual who pays cash or the cash equivalent, for the same health care service or item in the absence of health insurance coverage. Failure to provide a disclosure in compliance with this subsection may result in a fine not to exceed $500 per incident.

Section 29. Section 395.3011, Florida Statutes, is created to read:

395.3011 Billing and collection activities.—

(1) As used in this section, the term "extraordinary collection action" means any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

(a) Selling the individual's debt to another party.

(b) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(c) Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.

(d) Actions that require a legal or judicial process, including, but not limited to:

1. Placing a lien on the individual's property;

2. Foreclosing on the individual's real property;

3. Attaching or seizing the individual's bank account or any other personal property;

4. Commencing a civil action against the individual;

5. Causing the individual's arrest; or

6. Garnishing the individual's wages.

(2) A facility may not engage in an extraordinary collection action against an individual to obtain payment for services:

(a) Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance.

(b) Before the facility has provided the individual with an itemized statement or bill.

(c) During an ongoing grievance process as described in s. 395.301(6) or an ongoing appeal of a claim adjudication.

(d) Before billing any applicable insurer and allowing the insurer to adjudicate a claim.

(e) For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient.

(f) While the individual:

1. Negotiates in good faith the final amount of a bill for services rendered; or

2. Complies with all terms of a payment plan with the facility.

Section 30. Subsections (5) and (6) of section 408.051, Florida Statutes, are renumbered as subsections (6) and (7), respectively, and a new subsection (5) is added to that section, to read:

408.051 Florida Electronic Health Records Exchange Act.—

(5) HOSPITAL DATA.—A hospital as defined in s. 395.002(12) which maintains certified electronic health record technology must make available admission, transfer, and discharge data to the agency's Florida Health Information Exchange program for the purpose of supporting public health data registries and patient care coordination. The agency may adopt rules to implement this subsection.

Section 31. Subsection (8) of section 409.909, Florida Statutes, is renumbered as subsection (10), paragraph (a) of

subsection (6) is amended, and new subsections (8) and (9) are added to that section, to read:

409.909 Statewide Medicaid Residency Program.—

(6) The Slots for Doctors Program is established to address the physician workforce shortage by increasing the supply of highly trained physicians through the creation of new resident positions, which will increase access to care and improve health outcomes for Medicaid recipients.

(a)1. Notwithstanding subsection (4), the agency shall annually allocate $100,000 to hospitals and qualifying institutions for each newly created resident position that is first filled on or after June 1, 2023, and filled thereafter, and that is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit.

2. Notwithstanding the requirement that a new resident position be created to receive funding under this subsection, the agency may allocate $100,000 to hospitals and qualifying institutions, pursuant to subparagraph 1., for up to 200 resident positions that existed before July 1, 2023, if such resident position:

a. Is in a physician specialty or subspecialty experiencing a statewide supply-and-demand deficit.

b. Has been unfilled for a period of 3 or more years.

c. Is subsequently filled on or after June 1, 2024, and remains filled thereafter.

d. Is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program.

3. If applications for resident positions under this paragraph exceed the number of authorized resident positions or the available funding allocated, the agency shall prioritize applications for resident positions that are in a primary care specialty as specified in paragraph (2)(a).

(8) A hospital or qualifying institution that receives state funds, including, but not limited to, intergovernmental transfers, for a graduate medical education program under any of the programs established under this chapter or under the General Appropriations Act, must annually report data to the agency in a format established by the agency. To facilitate ongoing analysis of the performance of the state's graduate medical education system, the agency shall consult with the Office of Program Policy Analysis and Government Accountability regarding the content of the data reported, the manner of reporting, and compilation of the data by the agency.

(a) Hospitals and qualifying institutions must report, at a minimum, the following:

1. For each program, the sponsoring institution, the program level, specialty and subspecialty as applicable, the number of approved and filled positions, and the location. As used in this section, the term "sponsoring institution" means an organization that oversees, supports, and administers one or more resident positions.

2. For each position, the year the position was created, whether the position is currently filled and whether there has been any period of time when the position was not filled, each state and federal funding source used to create or maintain the position, and the general purpose for which the funds were used.

3. For each filled position, the current program year of the resident who is filling the position, the specialty or subspecialty for which the position is accredited, and whether the position is a fellowship position.

4. For each sponsoring institution, the number of programs, number of approved and filled positions, and sponsoring institution location.

(b) Specific to funds allocated pursuant to subsection (5) on or after July 1, 2021, the data must include, but is not limited to, all of the following:

1. The date on which the hospital or qualifying institution applied for funds under the program.

2. The date on which the position funded by the program became accredited.

3. The date on which the position was first filled and whether it has remained filled.

4. The specialty of the position created.

(c) Beginning on July 1, 2025, each hospital or qualifying institution shall annually produce detailed financial records no later than 30 days after the end of its fiscal year, detailing the manner in which state funds allocated under this section were expended. This requirement does not apply to funds allocated before July 1, 2025. The agency may also require that any hospital or qualifying institution submit to an audit of its financial records related to funds allocated under this section after July 1, 2025.

(d) If a hospital or qualifying institution fails to produce records as required by this section, such hospital or qualifying institution is no longer eligible to participate in any program established under this section until the hospital or qualifying institution has met the agency's requirements for producing the required records.

(e) Upon completion of a residency, each hospital or qualifying institution must request that the resident fill out an exit survey on a form developed by the agency. The completed exit surveys must be provided to the agency annually. The exit survey must include, but need not be limited to, questions on all of the following:

1. Whether the exiting resident has procured employment.

2. Whether the exiting resident plans to leave the state and, if so, for which reasons.

3. Where and in which specialty the exiting resident intends to practice.

4. Whether the exiting resident envisions himself or herself working in the medical field as a long-term career.

(9) The Graduate Medical Education Committee is created within the agency.

(a) The committee shall be composed of the following members:

1. Three deans, or the deans' designees, from medical schools in the state, appointed by the chair of the Council of Florida Medical School Deans.

2. Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association, one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under chapter 458 or chapter 459 practicing at a qualifying institution.

3. Two members appointed by the Secretary of Health Care Administration, one of whom represents a statutory teaching hospital as defined in s. 408.07(46) and one of whom is a physician who has supervised or is currently supervising

residents.

4. Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07 and one of whom is a physician who has supervised or is currently supervising residents or interns.

5. Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

(b)1. The members of the committee appointed under subparagraph (a)1. shall serve 4-year terms. When such members' terms expire, the chair of the Council of Florida Medical School Deans shall appoint new members as detailed in paragraph (a)1. from different medical schools on a rotating basis and may not reappoint a dean from a medical school that has been represented on the committee until all medical schools in the state have had an opportunity to be represented on the committee.

2. The members of the committee appointed under subparagraphs (a)2., 3., and 4. shall serve 4-year terms, with the initial term being 3 years for members appointed under subparagraph (a)4. and 2 years for members appointed under subparagraph (a)3. The committee shall elect a chair to serve for a 1-year term.

(c) Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

(d) The committee shall convene its first meeting by July 1, 2024, and shall meet as often as necessary to conduct its business, but at least twice annually, at the call of the chair. The committee may conduct its meetings though teleconference or other electronic means. A majority of the members of the committee constitutes a quorum, and a meeting may not be held with less than a quorum present. The affirmative vote of a majority of the members of the committee present is necessary for any official action by the committee.

(e) Beginning on July 1, 2025, the committee shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual report that must, at a minimum, detail all of the following:

1. The role of residents and medical faculty in the provision of health care.

2. The relationship of graduate medical education to the state's physician workforce.

3. The typical workload for residents and the role such workload plays in retaining physicians in the long-term workforce.

4. The costs of training medical residents for hospitals and qualifying institutions.

5. The availability and adequacy of all sources of revenue available to support graduate medical education.

6. The use of state funds, including, but not limited to,

intergovernmental transfers, for graduate medical education for each hospital or qualifying institution receiving such funds.

(f) The agency shall provide reasonable and necessary support staff and materials to assist the committee in the performance of its duties. The agency shall also provide the information obtained pursuant to subsection (8) to the committee and assist the committee, as requested, in obtaining any other information deemed necessary by the committee to produce its report.

Section 32. Section 409.91256, Florida Statutes, is created to read:

409.91256 Training, Education, and Clinicals in Health (TEACH) Funding Program.—

(1) PURPOSE AND INTENT.—The Training, Education, and Clinicals in Health (TEACH) Funding Program is created to provide a high-quality educational experience while supporting participating qualified health centers, community mental health centers, rural health clinics, and certified community behavioral health clinics by offsetting administrative costs and loss of revenue associated with training residents and students to become licensed health care practitioners. Further, it is the intent of the Legislature to use the program to support the state Medicaid program and underserved populations by expanding the available health care workforce.

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Preceptor" means a Florida-licensed health care practitioner who directs, teaches, supervises, and evaluates the learning experience of a resident or student during a clinical rotation.

(c) "Primary care specialty" means general internal medicine, family medicine, obstetrics and gynecology, pediatrics, psychiatry, geriatric medicine, or any other specialty the agency identifies as primary care.

(d) "Qualified facility" means a federally qualified health center, a community mental health center, rural health clinic, or a certified community behavioral health clinic.

(3) APPLICATION FOR REIMBURSEMENT; AGREEMENTS; PARTICIPATION REQUIREMENTS.—The agency shall develop an application process for qualified facilities to apply for funds to offset the administrative costs and loss of revenue associated with establishing, maintaining, or expanding a clinical training program. Upon approving an application, the agency shall enter into an agreement with the qualified facility which, at minimum, must require each qualified facility to do all of the following:

(a) Agree to provide appropriate supervision or precepting for one or more of the following categories of residents or students:

1. Allopathic or osteopathic residents pursuing a primary care specialty.

2. Advanced practice registered nursing students pursuing a primary care specialty.

3. Nursing students.

4. Allopathic or osteopathic medical students.

5. Dental students.

6. Physician assistant students.

7. Behavioral health students, including students studying psychology, clinical social work, marriage and family therapy, or mental health counseling.

(b) Meet and maintain all requirements to operate an accredited residency program if the qualified facility operates a residency program.

(c) Obtain and maintain accreditation from an accreditation body approved by the agency if the qualified facility provides clinical rotations.

(d) Ensure that clinical preceptors meet agency standards for precepting students, including the completion of any training required by the agency.

(e) Submit to the agency quarterly reports by the first day of the second month following the end of a quarter to obtain reimbursement. At a minimum, the report must include all of the following:

1. The type of residency or clinical rotation offered by

the qualified facility, the number of residents or students participating in each type of clinical rotation or residency, and the number of hours worked by each resident or student each month.

2. Evaluations by the residents and student participants of the clinical experience on an evaluation form developed by the agency.

3. An itemized list of administrative costs associated with the operation of the clinical training program, including accreditation costs and other costs relating to the creation, implementation, and maintenance of the program.

4. A calculation of lost revenue associated with operating the clinical training program.

(4) TRAINING.—The agency, in consultation with the Department of Health, shall develop, or contract for the development of, training for preceptors and make such training available in either a live or electronic format. The agency shall also provide technical support for preceptors.

(5) REIMBURSEMENT.—A qualified facility may be reimbursed under this section only to offset the administrative costs or lost revenue associated with training students, allopathic residents, or osteopathic residents who are enrolled in an accredited educational or residency program based in the state.

(a) Subject to an appropriation, the agency may reimburse a qualified facility based on the number of clinical training

hours reported under subparagraph (3)(e)1. The allowed reimbursement per student is as follows:

1. A medical resident at a rate of $50 per hour.

2. A first-year medical student at a rate of $27 per hour.

3. A second-year medical student at a rate of $27 per hour.

4. A third-year medical student at a rate of $29 per hour.

5. A fourth-year medical student at a rate of $29 per hour.

6. A dental student at a rate of $22 per hour.

7. An advanced practice registered nursing student at a rate of $22 per hour.

8. A physician assistant student at a rate of $22 per hour.

9. A behavioral health student at a rate of $15 per hour.

(b) A qualified facility may not be reimbursed more than $75,000 per fiscal year; however, if it operates a residency program, it may be reimbursed up to $100,000 each fiscal year.

(6) DATA.—A qualified facility that receives payment under the program shall furnish information requested by the agency for the purpose of the agency's duties under subsections (7) and (8).

(7) REPORTS.—By December 1, 2025, and each December 1 thereafter, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of

Representatives a report detailing the effects of the program for the prior fiscal year, including, but not limited to, all of the following:

(a) The number of students trained in the program, by school, area of study, and clinical hours earned.

(b) The number of students trained and the amount of program funds received by each participating qualified facility.

(c) The number of program participants found to be employed by a qualified facility or in a federally designated health professional shortage area upon completion of such participants' education and training.

(d) Any other data the agency deems useful for determining the effectiveness of the program.

(8) EVALUATION.—The agency shall contract with an independent third party to develop and conduct a design study to evaluate the impact of the TEACH funding program, including, but not limited to, the program's effectiveness in both of the following areas:

(a) Enabling qualified facilities to provide clinical rotations and residency opportunities to students and medical school graduates, as applicable.

(b) Enabling the recruitment and retention of health care professionals in geographic and practice areas experiencing shortages.

The agency shall begin collecting data for the study by January 1, 2025, and shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2030.

(9) RULES.—The agency may adopt rules to implement this section.

(10) FEDERAL FUNDING.—The agency shall seek federal approval to use Title XIX matching funds for the program.

(11) REPEAL.—This section is repealed on July 1, 2034.

Section 33. Paragraph (e) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(e) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in

accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

4. The agency shall annually produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees." The report must include, but need not be limited to, an analysis of the potentially preventable hospital emergency department visits, hospital admissions, and hospital readmissions that occurred during the previous state

fiscal year which may have been prevented with better access to primary care, improved medication management, or better coordination of care, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each potentially preventable event or category of potentially preventable events. The agency may include any other data or analysis parameters to augment the report that it deems pertinent to the analysis. The report must demonstrate trends using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

Section 34. Subsection (4) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible, the appointment should be made within 30 days after enrollment in the plan. If an appointment is not made within such 30-day period, the plan must continue assisting the enrollee to schedule an initial appointment.

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

(f) Coordinate with a hospital that contacts the plan under the requirements of s. 395.1055(1)(j) for the purpose of establishing the appropriate delivery of primary care services for the plan's members who present at the hospital's emergency department for nonemergent care or emergency care that could potentially have been avoided through the regular provision of primary care. The plan shall coordinate with such member and the member's primary care provider for such purpose.

Section 35. The Agency for Health Care Administration shall seek federal approval necessary to implement an acute

hospital care at home program in the state Medicaid program which is substantially consistent with the parameters specified in 42 U.S.C. s. 1395cc-7(a)(2)-(3).

Section 36. Section 456.0145, Florida Statutes, is created to read:

456.0145 Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.—

(1) SHORT TITLE.—This section may be cited as the "Mobile Opportunity by Interstate Licensure Endorsement Act" or the "MOBILE Act."

(2) LICENSURE BY ENDORSEMENT.—

(a) An applicable board, or the department if there is no board, shall issue a license to practice in this state to an applicant who:

1. Submits a complete application.

2. Holds an active, unencumbered license issued by another state, the District of Columbia, or a possession or territory of the United States in a profession with a similar scope of practice, as determined by the board or department, as applicable. "Scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

3. Has obtained a passing score on a national licensure examination, or national certification, as applicable, for which

profession the applicant is seeking licensure in this state, or meets the requirements of paragraph (b).

4. Has actively practiced the profession for which the applicant is applying for at least 2 of the 4 years preceding the date of submission of the application.

5. Attests that he or she is not, at the time of submission of the application, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reasons related to the practice of the profession for which he or she is applying.

6. Has not had disciplinary action taken against him or her in the 5 years preceding the date of submission of the application

7. Meets the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure.

8. Submits a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

The department shall verify information submitted by the applicant under this subsection using the National Practitioner Data Bank.

(b) An applicant for a profession that does not require a

national examination or national certification is eligible for licensure if an applicable board or the department determines that the jurisdiction in which the applicant currently holds an active, unencumbered license meets established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements that are substantially similar to the requirements for licensure in that profession in this state.

(c) An applicant is ineligible for a license pursuant to this section if he or she:

1. Has a complaint, allegation, or investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;

2. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

3. Has had a health care provider license revoked or suspended in another state of the United States, the District of Columbia, or a United States territory or has voluntarily surrendered any such license; or

4. Has been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank.

(d) The board, or the department if there is no board, may revoke a license upon finding that the applicant provided false

or misleading material information or intentionally omitted material information in an application for licensure.

(e) The board, or the department if there is no board, shall issue a license within 7 days after receipt of all required documentation for an application.

(f) The board, or the department if there is no board, shall comply with the requirements of s. 456.025.

(3) STATE EXAMINATION.—The board, or the department if there is no board, may require the applicant to successfully complete a jurisprudential examination specific to relevant state laws that regulate the profession, if this chapter or the applicable practice act requires such examination.

(4) ANNUAL REPORT.—By December 31 of each year, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that provides all of the following information for the previous fiscal year:

(a) The number of applications for licensure or certification received under this section, distinguished by profession.

(b) The number of licenses or certifications issued under this section.

(c) The number of applications submitted under this section which were denied and the reason for such denials.

(d) The number of complaints, investigations, or other

disciplinary actions taken against health care practitioners who are licensed or certified under this section.

(5) RULES.—By December 1, 2024, each applicable board, or the department if there is no board, shall adopt rules to implement this section.

Section 37. Subsection (10) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.—Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(10)(a) The complaint and all information obtained pursuant to the investigation by the department are confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department, or until the regulated professional or subject of the investigation waives his or her privilege of confidentiality, whichever occurs first.

(b) The department shall report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure information system pursuant to s. 464.0095; any investigative information relating to an audiologist or a speech-language pathologist holding a compact privilege under the Practice of Audiology and Speech-Language Pathology Interstate Compact to the data system pursuant to s. 468.1335; any significant investigatory

information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075; ~~,~~ and any significant investigatory information relating to a health care practitioner practicing under the Professional Counselors Licensure Compact to the data system pursuant to s. 491.017~~, and any significant investigatory information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075~~.

(c) Upon completion of the investigation and a recommendation by the department to find probable cause, and pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an opportunity to inspect the investigative file or, at the subject's expense, forward to the subject a copy of the investigative file. Notwithstanding s. 456.057, the subject may inspect or receive a copy of any expert witness report or patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any information received under this subsection until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 456.057. The subject may file a written response to the information contained in the investigative file. Such response must be filed within 20 days

of mailing by the department, unless an extension of time has been granted by the department.

(d) This subsection does not prohibit the department from providing the complaint and any information obtained pursuant to the department's investigation ~~such information~~ to any law enforcement agency or to any other regulatory agency.

Section 38. Subsection (5) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

(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. If the impaired practitioner is a physical therapist or physical therapist assistant practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, a psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, or a health care practitioner practicing under the Professional Counselors Licensure Compact

pursuant to s. 491.017, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact. If the impaired practitioner is a physical therapist or physical therapist assistant practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112 ~~psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075~~, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact unless authorized by a member state.

Section 39. Section 456.4501, Florida Statutes, is created to read:

456.4501 Interstate Medical Licensure Compact.—The Interstate Medical Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

SECTION 1

PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of

state medical boards and provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing medical practice act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

SECTION 2

DEFINITIONS

As used in this compact, the term:

(1) "Bylaws" means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance, or for directing and controlling its actions and conduct.

(2) "Commissioner" means the voting representative appointed by each member board pursuant to Section 11.

(3) "Convicted" means a finding by a court that an individual is guilty of a criminal offense through adjudication or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(4) "Expedited license" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

(5) "Interstate Commission" means the Interstate Medical Licensure Compact Commission created pursuant to Section 11.

(6) "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(7) "Medical practice act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(8) "Member board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

(9) "Member state" means a state that has enacted the Compact.

(10) "Offense" means a felony, high court misdemeanor, or crime of moral turpitude.

(11) "Physician" means any person who:

(a) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(b) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(c) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(d) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; however, the specialty certification or a time-unlimited specialty certificate does not have to be maintained once a physician is initially determined to be eligible for expedited licensure through the Compact;

(e) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(f) Has never been convicted, received adjudication,

deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(g) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(h) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(i) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(12) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do any of these acts.

(13) "Rule" means a written statement by the Interstate Commission adopted pursuant to section 12 of the compact which is of general applicability; implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the Interstate Commission; and has the force and effect of statutory

law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule.

(14) "State" means any state, commonwealth, district, or territory of the United States.

(15) "State of principal license" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.

SECTION 3

ELIGIBILITY

(1) A physician must meet the eligibility requirements as provided in subsection (11) of section 2 to receive an expedited license under the terms and provisions of the Compact.

(2) A physician who does not meet the requirements as provided in subsection (11) of section 2 may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the Compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4

DESIGNATION OF STATE OF PRINCIPAL LICENSE

(1) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(a) The state of primary residence for the physician, or

(b) The state where at least 25 percent of the physician's practice of medicine occurs, or

(c) The location of the physician's employer, or

(d) If no state qualifies under paragraph (a), paragraph (b), or paragraph (c), the state designated as the state of residence for purpose of federal income tax.

(2) A physician may redesignate a member state as the state of principal license at any time, as long as the state meets one of the descriptions under subsection (1).

(3) The Interstate Commission may develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5

APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(1) A physician seeking licensure through the compact must file an application for an expedited license with the member board of the state selected by the physician as the state of

principal license.

(2) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(a) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, are not subject to additional primary source verification if already primary source verified by the state of principal license.

(b) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have a suitability determination in accordance with U.S. 5 C.F.R. s. 731.202.

(c) Appeal on the determination of eligibility must be made to the member state where the application was filed and is subject to the law of that state.

(3) Upon verification in subsection (2), physicians

eligible for an expedited license must complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (1), including the payment of any applicable fees.

(4) After receiving verification of eligibility under subsection (2) and upon an applicant's completion of any registration process, including the payment of any applicable fees, required under subsection (3), a member board shall issue an expedited license to the physician. This license authorizes the physician to practice medicine in the issuing state consistent with the medical practice act and all applicable laws and regulations of the issuing member board and member state.

(5) An expedited license is valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

(6) An expedited license obtained through the compact must be terminated if a physician fails to maintain a license in the state of principal licensure for a nondisciplinary reason, without redesignation of a new state of principal licensure.

(7) The Interstate Commission may develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

SECTION 6

FEES FOR EXPEDIATED LICENSURE

(1) A member state issuing an expediated license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the compact.

(2) The Interstate Commission is authorized to develop rules regarding fees for expediated licenses.

SECTION 7

RENEWAL AND CONTINUED PARTICIPATION

(1) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(a) Maintains a full and unrestricted license in a state of principal license;

(b) Has not been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(c) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license; and

(d) Has not had a controlled substance license or permit

suspended or revoked by a state or the United States Drug Enforcement Administration.

(2) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(3) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(4) Upon receipt of any renewal fees collected in subsection (3), a member board shall renew the physician's license.

(5) Physician information collected by the Interstate Commission during the renewal process must distributed to all member boards.

(6) The Interstate Commission may develop rules to address renewal of licenses obtained through the Compact.

SECTION 8

COORDINATED INFORMATION SYSTEM

(1) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(2) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public

action or complaints against a licensed physician who has applied or received an expedited license through the Compact.

(3) Member boards shall report to the Interstate Commission disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(4) Member boards may report to the Interstate Commission any nonpublic complaint, disciplinary, or investigatory information not required by subsection (3) to the Interstate Commission.

(5) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(6) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission may develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9

JOINT INVESTIGATIONS

(1) Licensure and disciplinary records of physicians are deemed investigative.

(2) In addition to the authority granted to a member board by its respective medical practice act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(3) A subpoena issued by a member state is enforceable in other member states.

(4) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(5) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10

DISCIPLINARY ACTIONS

(1) Any disciplinary action taken by any member board against a physician licensed through the compact is deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the medical practice act or regulations in that state.

(2) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered

or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board must remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the medical practice act of that state.

(3) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(a) Impose the same or lesser sanctions against the physician so long as such sanctions are consistent with the medical practice act of that state; or

(b) Pursue separate disciplinary action against the physician under its respective medical practice act, regardless of the action taken in other member states.

(4) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, any licenses issued to the physician by any other member boards, for 90 days after entry of the order by the disciplining board, to permit the member boards to investigate the basis for the action under the medical practice act of that

state. A member board may terminate the automatic suspension of the license it issued before the completion of the ninety (90) day suspension period in a manner consistent with the medical practice act of that state.

SECTION 11

INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(1) The member states hereby create the "Interstate Medical Licensure Compact Commission."

(2) The purpose of the Interstate Commission is the administration of the compact, which is a discretionary state function.

(3) The Interstate Commission is a body corporate and joint agency of the member states and has all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

(4) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall

appoint one representative from each member board. Each commissioner must be one of the following:

(a) An allopathic or osteopathic physician appointed to a member board;

(b) An executive director, an executive secretary, or a similar executive of a member board; or

(c) A member of the public appointed to a member board.

(5) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting must be a business meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(6) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or other electronic means.

(7) Each commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of commissioners constitutes a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A commissioner may not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who must meet the qualification requirements specified in subsection (4).

(8) The Interstate Commission shall provide public notice of all meetings, and all meetings must be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that an open meeting would be likely to:

(a) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(b) Discuss matters specifically exempted from disclosure by federal statute;

(c) Discuss trade secrets or commercial or financial information that is privileged or confidential;

(d) Involve accusing a person of a crime, or formally censuring a person;

(e) Discuss information of a personal nature where disclosure of which would constitute a clearly unwarranted invasion of personal privacy;

(f) Discuss investigative records compiled for law enforcement purposes; or

(g) Specifically relate to the participation in a civil action or other legal proceeding.

(9) The Interstate Commission shall keep minutes that fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including a record of any roll call votes.

(10) The Interstate Commission shall make its information

and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

(11) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee has the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the compact, including enforcement and compliance with the compact, its bylaws and rules, and other such duties as necessary.

(12) The Interstate Commission may establish other committees for governance and administration of the compact.

SECTION 12

POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission has all of the following powers and duties:

(1) Overseeing and maintaining the administration of the compact.

(2) Adopting rules which shall be binding to the extent and in the manner provided for in the compact.

(3) Issuing, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules, and actions.

(4) Enforcing compliance with the compact, the rules adopted by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process.

(5) Establishing and appointing committees, including, but not limited to, an executive committee as required by section 10, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties.

(6) Paying for, or providing for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission.

(7) Establishing and maintaining one or more offices;

(8) Borrowing, accepting, hiring, or contracting for services of personnel.

(9) Purchasing and maintaining insurance and bonds.

(10) Employing an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation.

(11) Establishing personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel.

(12) Accepting donations and grants of money, equipment, supplies, materials and services, and receiving, using, and disposing of it in a manner consistent with the conflict of interest policies established by the Interstate Commission.

(13) Leasing, purchasing, accepting contributions or donations of, or otherwise to owning, holding, improving, or using, any property, real, personal, or mixed.

(14) Selling, conveying, mortgaging, pledging, leasing, exchanging, abandoning, or otherwise disposing of any property, real, personal, or mixed.

(15) Establishing a budget and making expenditures.

(16) Adopting a seal and bylaws governing the management and operation of the Interstate Commission.

(17) Reporting annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports must also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission.

(18) Coordinating education, training, and public awareness regarding the compact and its implementation and operation;

(19) Maintaining records in accordance with the bylaws.

(20) Seeking and obtaining trademarks, copyrights, and patents.

(21) Performing any other functions necessary or

appropriate to achieve the purposes of the compact.

SECTION 13

FINANCE POWERS

(1) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment, subject to appropriation, must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated upon a formula to be determined by the Interstate Commission, which shall adopt a rule binding upon all member states.

(2) The Interstate Commission may not incur obligations of any kind prior to securing the funds adequate to meet the same.

(3) The Interstate Commission may not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(4) The Interstate Commission is subject to an annual financial audit conducted by a certified or licensed public accountant and the report of the audit must be included in the annual report of the Interstate Commission.

SECTION 14

ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(1) The Interstate Commission shall, by a majority of commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact within 12 months after the first Interstate Commission meeting.

(2) The Interstate Commission shall elect or appoint annually from among its commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(3) Officers selected pursuant to subsection (2) shall serve without remuneration from the Interstate Commission.

(4) The officers and employees of the Interstate Commission are immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person is not protected from suit or

liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(a) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purposes of any such action. This subsection does not protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(b) The Interstate Commission shall defend the executive director and its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such persons in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged

act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(c) To the extent not covered by the state involved, the member state, or the Interstate Commission, the representatives or employees of the Interstate Commission must be held harmless in the amount of a settlement or judgment, including attorney fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

SECTION 15

RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(1) The Interstate Commission shall adopt reasonable rules in order to effectively and efficiently achieve the purposes of the compact. However, in the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the Interstate Commission is

invalid and has no force or effect.

(2) Rules deemed appropriate for the operations of the Interstate Commission must be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(3) Not later than 30 days after a rule is adopted, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition does not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court must give deference to the actions of the Interstate Commission consistent with applicable law and does not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16

OVERSIGHT OF INTERSTATE COMPACT

(1) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to

effectuate the compact's purposes and intent. The compact and the rules adopted hereunder has standing as statutory law but may not override existing state authority to regulate the practice of medicine.

(2) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(3) The Interstate Commission is entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the compact, or adopted rules, as applicable.

SECTION 17

ENFORCEMENT OF INTERSTATE COMPACT

(1) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the Compact.

(2) The Interstate Commission may, by majority vote of the commissioners, initiate legal action in the United States

District Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the compact, and its adopted rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party must be awarded all costs of such litigation including reasonable attorney fees.

(3) The remedies herein are not the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 18

DEFAULT PROCEDURES

(1) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the compact, or the rules and bylaws of the Interstate Commission adopted under the compact.

(2) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or adopted

rules, the Interstate Commission shall:

(a) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

(b) Provide remedial training and specific technical assistance regarding the default.

(3) If the defaulting state fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the commissioners and all rights, privileges, and benefits conferred by the compact shall terminate on the effective date of the termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(4) Termination of membership in the compact must be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate must be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(5) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the

withdrawal of a member state.

(6) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination, including obligations, the performance of which extends beyond the effective date of termination.

(7) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(8) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party must be awarded all costs of such litigation including reasonable attorney's fees.

SECTION 19

DISPUTE RESOLUTION

(1) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes that are subject to the compact and that may arise among member states or member boards.

(2) The Interstate Commission shall adopt rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20

MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(1) Any state is eligible to become a member state of the compact.

(2) The Compact shall become effective and binding upon legislative enactment of the compact into law by no less than 7 states. Thereafter, it becomes effective and binding on a state upon enactment of the compact into law by that state.

(3) The governors of nonmember states, or their designees, must be invited to participate in the activities of the Interstate Commission on a nonvoting basis before adoption of the compact by all states.

(4) The Interstate Commission may propose amendments to the compact for enactment by the member states. An amendment does not become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21

WITHDRAWAL

(1) Once effective, the compact shall continue in force and remain binding upon each and every member state. However, a member state may withdraw from the compact by specifically repealing the statute which enacted the Compact into law.

(2) Withdrawal from the compact must be made by the enactment of a statute repealing the same, but the withdrawal may not take effect until one year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(3) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(4) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within 60 days after the receipt of notice provided under subsection (3).

(5) The withdrawing state is responsible for all dues, obligations, and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(6) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or

upon such later date as determined by the Interstate Commission.

(7) The Interstate Commission may develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22

DISSOLUTION

(1) The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the compact to one member state.

(2) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission must be concluded, and surplus funds of the Interstate Commission must be distributed in accordance with the bylaws.

SECTION 23

SEVERABILITY AND CONSTRUCTION

(1) The provisions of the compact are be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact remain

enforceable.

(2) The provisions of the compact must be liberally construed to effectuate its purposes.

(3) The compact does not prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) Nothing herein prevents the enforcement of any other law of a member state which is not inconsistent with the Compact.

(2) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(3) All lawful actions of the Interstate Commission, including all rules and bylaws adopted by the commission, are binding upon the member states.

(4) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(5) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision is ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 40. Section 456.4502, Florida Statutes, is created

to read:

456.4502 Interstate Medical Licensure Compact; disciplinary proceedings.—A physician licensed pursuant to chapter 458, chapter 459, or s. 456.4501 whose license is suspended or revoked by this state pursuant to the Interstate Medical Licensure Compact as a result of disciplinary action taken against the physician's license in another state must be granted a formal hearing before an administrative law judge from the Division of Administrative Hearings held pursuant to chapter 120 if there are any disputed issues of material fact. In such proceedings:

(1) Notwithstanding s. 120.569(2), the department shall notify the division within 45 days after receipt of a petition or request for a formal hearing.

(2) The determination of whether the physician has violated the laws and rules regulating the practice of medicine or osteopathic medicine, as applicable, including a determination of the reasonable standard of care, is a conclusion of law that is to be determined by appropriate board, and is not a finding of fact to be determined by an administrative law judge.

(3) The administrative law judge shall issue a recommended order pursuant to chapter 120.

(4) The Board of Medicine or the Board of Osteopathic Medicine, as applicable, shall determine and issue the final

order in each disciplinary case. Such order shall constitute final agency action.

(5) Any consent order or agreed-upon settlement is subject to the approval of the department.

(6) The department shall have standing to seek judicial review of any final order of the board, pursuant to s. 120.68.

Section 41. Section 456.4504, Florida Statutes, is created to read:

456.4504 Interstate Medical Licensure Compact Rules.—The department may adopt rules to implement the Interstate Medical Licensure Compact.

Section 42. The provisions of the Interstate Medical Licensure Compact do not authorize the Department of Health, the Board of Medicine, or the Board of Osteopathic Medicine to collect a fee for expedited licensure, but rather state that such fees are allowable under the compact. The Department of Health, the Board of Medicine, and the Board of Osteopathic Medicine must comply with the requirements of s. 456.025.

Section 43. Paragraph (c) of subsection (2) of section 457.105, Florida Statutes, is amended to read:

457.105 Licensure qualifications and fees.—

(2) A person may become licensed to practice acupuncture if the person applies to the department and:

(c) Has successfully completed a board-approved national certification process, meets the requirements for licensure by

endorsement in s. 456.0145 ~~is actively licensed in a state that has examination requirements that are substantially equivalent to or more stringent than those of this state~~, or passes an examination administered by the department, which examination tests the applicant's competency and knowledge of the practice of acupuncture and oriental medicine. At the request of any applicant, oriental nomenclature for the points shall be used in the examination. The examination shall include a practical examination of the knowledge and skills required to practice modern and traditional acupuncture and oriental medicine, covering diagnostic and treatment techniques and procedures; and

Section 44. Subsections (3) through (8) of section 458.311, Florida Statutes, are renumbered as subsections (4) through (9), respectively, paragraph (f) of subsection (1) and present subsections (3) and (5) are amended, and a new subsection (3) is added to that section, 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:

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting

agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission for Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

3.a. Is a graduate of an allopathic foreign medical school

which has not been certified pursuant to s. 458.314 and has not been excluded from consideration under s. 458.314(8);

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

(3) Notwithstanding sub-subparagraphs (1)(f)2.c. and 3.c., a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) is not required to complete an approved residency if he or she meets all of the following criteria:

(a) Has an active, unencumbered license to practice medicine in a foreign country.

(b) Has actively practiced medicine in the 4-year period preceding the date of the submission of a licensure application.

(c) Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction.

(d) Has an offer for full-time employment as a physician from a health care provider that operates in this state.

A physician licensed after meeting the requirements of this subsection must maintain his or her employment with the original employer under paragraph (d) or with another health care provider that operates in this state, at a location within this state, for at least 2 consecutive years after licensure, in accordance with rules adopted by the board. Such physician must notify the board within 5 business days after any change of employer.

(4) ~~(3)~~ Notwithstanding the provisions of subparagraph (1)(f)3., a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) need not present the certificate issued by the Educational Commission for Foreign Medical Graduates or pass the examination utilized by that commission if the graduate:

(a) Has received a bachelor's degree from an accredited United States college or university.

(b) Has studied at a medical school which is recognized by the World Health Organization.

(c) Has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has passed part I of the National Board of Medical Examiners examination or the Educational Commission for

Foreign Medical Graduates examination equivalent.

(d) Has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion has passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(6) ~~(5)~~ The board may not certify to the department for licensure any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, ~~the provisions of~~ s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, ~~then~~ the board may enter an order imposing one or more of the terms set forth in subsection (9) ~~(8)~~.

Section 45. Section 458.3124, Florida Statutes, is repealed.

Section 46. Section 458.313, Florida Statutes, is amended

to read:

458.313 Licensure by endorsement; requirements; fees.—

~~(1)~~ The department shall issue a license by endorsement to any applicant who, upon applying to the department on forms furnished by the department and remitting a fee set by the board not to exceed $500, the board certifies has met the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Has met the qualifications for licensure in s. 458.311(1)(b)-(g) or in s. 458.311(1)(b)-(e) and (g) and (3);~~

~~(b) Prior to January 1, 2000, has obtained a passing score, as established by rule of the board, on the licensure examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), on the United States Medical Licensing Examination (USMLE), or on the examination of the National Board of Medical Examiners, or on a combination thereof, and on or after January 1, 2000, has obtained a passing score on the United States Medical Licensing Examination (USMLE); and~~

~~(c) Has submitted evidence of the active licensed practice of medicine in another jurisdiction, for at least 2 of the immediately 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. For~~

~~purposes of this paragraph, "active licensed practice of 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, medical directors under s. 641.495(11) who are practicing medicine, and those on the active teaching faculty of an accredited medical school.~~

~~(2) The board may require an applicant for licensure by endorsement to take and pass the appropriate licensure examination prior to certifying the applicant as eligible for licensure.~~

~~(3) The department and the board shall ensure that applicants for licensure by endorsement meet applicable criteria in this chapter through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(1) and the department or board has reason to believe that the applicant does not meet the criteria, the State Surgeon General or the State Surgeon General's designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(1).~~

~~(4) The board may promulgate rules and regulations, to be applied on a uniform and consistent basis, which may be necessary to carry out the provisions of this section.~~

~~(5) Upon certification by the board, the department shall~~

~~impose conditions, limitations, or restrictions on a license by endorsement if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter.~~

~~(6) The department shall not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, the board may enter an order imposing one or more of the terms set forth in subsection (7).~~

~~(7) When the board determines that any applicant for licensure by endorsement has failed to meet, to the board's satisfaction, each of the appropriate requirements set forth in this section, it may enter an order requiring one or more of the following terms:~~

~~(a) Refusal to certify to the department an application for licensure, certification, or registration;~~

~~(b) Certification to the department of an application for~~

~~licensure, certification, or registration with restrictions on the scope of practice of the licensee; or~~

~~(c) Certification to the department 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 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.~~

Section 47. Subsection (8) of section 458.314, Florida Statutes, is amended to read:

458.314 Certification of foreign educational institutions.—

(8) If a foreign medical school does not seek certification under this section, the board may, at its discretion, exclude the foreign medical school from consideration as an institution that provides medical education that is reasonably comparable to that of similar accredited institutions in the United States and that adequately prepares its students for the practice of medicine in this state. However, a license or medical faculty certificate issued to a physician under this chapter before July 1, 2024, is not affected by this subsection ~~Each institution which has been surveyed before October 1, 1986, by the Commission to Evaluate Foreign Medical Schools or the Commission on Foreign Medical~~

~~Education of the Federation of State Medical Boards, Inc., and whose survey and supporting documentation demonstrates that it provides an educational program, including curriculum, reasonably comparable to that of similar accredited institutions in the United States shall be considered fully certified, for purposes of chapter 86-245, Laws of Florida~~.

Section 48. Subsections (5) and (6) of section 458.3145, Florida Statutes, are renumbered as subsections (4) and (5), respectively, and subsection (1) and present subsection (4) of that section are amended, to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who meets all of the following criteria:

(a) Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization which has not been excluded from consideration under s. 458.314(8).~~;~~

(b) Holds a valid, current license to practice medicine in another jurisdiction.~~;~~

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed $500.~~;~~

(d) Has completed an approved residency or fellowship of at least 1 year or has received training that ~~which~~ has been determined by the board to be equivalent to the 1-year residency

requirement.~~;~~

(e) Is at least 21 years of age.~~;~~

(f) Is of good moral character.~~;~~

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331.~~;~~

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry.~~; and~~

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at any of the following institutions:

1. The University of Florida.~~;~~

2. The University of Miami.~~;~~

3. The University of South Florida.~~;~~

4. The Florida State University.~~;~~

5. The Florida International University.~~;~~

6. The University of Central Florida.~~;~~

7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida.~~;~~

8. The Florida Atlantic University.~~;~~

9. The Johns Hopkins All Children's Hospital in St.

Petersburg, Florida.~~;~~

10. Nova Southeastern University.~~; or~~

11. Lake Erie College of Osteopathic Medicine.

~~(4) In any year, the maximum number of extended medical faculty certificateholders as provided in subsection (2) may not exceed 30 persons at each institution named in subparagraphs (1)(i)1.-6., 8., and 9. and at the facility named in s. 1004.43 and may not exceed 10 persons at the institution named in subparagraph (1)(i)7.~~

Section 49. Section 458.315, Florida Statutes, is amended to read:

458.315 Temporary certificate for practice in areas of critical need.—

(1) A physician or physician assistant who is licensed to practice in any jurisdiction of the United States and~~,~~ whose license is currently valid~~, and who pays an application fee of $300~~ may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300.

(2) A temporary certificate may be issued under this section to a physician or physician assistant who will:

(a) ~~Will~~ Practice in an area of critical need;

(b) ~~Will~~ Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s.

330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care services to meet the needs of underserved populations in this state; or

(c) ~~Will~~ Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The board ~~of Medicine~~ may issue a ~~this~~ temporary certificate under this section subject to ~~with~~ the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.

(b) The board may administer an abbreviated oral

examination to determine the physician's or physician assistant's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application ~~prior 3 years~~ and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid

only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The board ~~of Medicine~~ shall review each temporary certificateholder at least ~~not less than~~ annually to ascertain that the certificateholder is complying with the minimum requirements of the Medical Practice Act and its adopted rules, as applicable to the certificateholder ~~are being complied with~~. If it is determined that the certificateholder is not meeting such minimum requirements ~~are not being met~~, the board must ~~shall~~ revoke such certificate or ~~shall~~ impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician or physician assistant who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time ~~the provisions of~~ s. 458.331 applies ~~apply~~.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or

institution stating that the physician or physician assistant will not receive any compensation for any health care services provided by the applicant ~~service involving the practice of medicine~~.

Section 50. Section 458.317, Florida Statutes, is amended to read:

458.317 Limited licenses.—

(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS.—

(a) Any person desiring to obtain a limited license under this subsection shall submit to the board an application and fee not to exceed $300 and demonstrate that he or she has been licensed to practice medicine in any jurisdiction in the United States for at least 10 years and intends to practice only pursuant to the restrictions of a limited license granted pursuant to this subsection ~~section~~. However, a physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of medicine.

(b) If it has been more than 3 years since active practice

was conducted by the applicant, the full-time director of the county health department or a licensed physician, approved by the board, must ~~shall~~ supervise the applicant for a period of 6 months after he or she is granted a limited license under this subsection ~~for practice~~, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure. Procedures for such supervision must ~~shall~~ be established by the board.

(c) The recipient of a limited license under this subsection may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in the areas of critical medical need as determined by the board. Determination of medically underserved areas shall be made by the board after consultation with the department ~~of Health~~ and statewide medical organizations; however, such determination shall include, but not be limited to, health professional shortage areas designated by the United States Department of Health and Human Services. A recipient of a limited license under this subsection may use the license to work for any approved employer in any area of critical need approved by the board.

(d) The recipient of a limited license shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all

approved institutions where practice privileges have been denied.

(e) This subsection does not limit ~~Nothing herein limits in any way~~ any policy by the board, otherwise authorized by law, to grant licenses to physicians duly licensed in other states under conditions less restrictive than the requirements of this subsection ~~section~~. Notwithstanding the other provisions of this subsection ~~section~~, the board may refuse to authorize a physician otherwise qualified to practice in the employ of any agency or institution otherwise qualified if the agency or institution has caused or permitted violations of the provisions of this chapter which it knew or should have known were occurring.

(f) ~~(2)~~ The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under ~~the provisions of~~ this subsection ~~act~~. The director of the full-time county health department shall assist in the supervision of any licensee within the county and shall notify the board ~~which issued the licensee his or her license~~ if he or she becomes aware of any actions by the licensee which would be grounds for revocation of the limited license. The board shall establish procedures for such supervision.

(g) ~~(3)~~ The board shall review the practice of each licensee biennially to verify compliance with the restrictions

prescribed in this subsection ~~section~~ and other applicable provisions of this chapter.

(h) ~~(4)~~ Any person holding an active license to practice medicine in this ~~the~~ state may convert that license to a limited license under this subsection for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine. The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for such applicant.

(2) GRADUATE ASSISTANT PHYSICIANS.— A graduate assistant physician is a medical school graduate who meets the requirements of this subsection and has obtained a limited license from the board for the purpose of practicing temporarily under the direct supervision of a physician who has a full, active, and unencumbered license issued under this chapter, pending the graduate's entrance into a residency under the National Resident Match Program.

(a) Any person desiring to obtain a limited license as a graduate assistant physician must submit to the board an application and demonstrate that he or she meets all of the following criteria:

1. Is a graduate of an allopathic medical school or

allopathic college approved by an accrediting agency recognized by the United States Department of Education.

2. Has successfully passed all parts of the United States Medical Licensing Examination.

3. Has not received and accepted a residency match from the National Resident Matching Program within the first year following graduation from medical school.

(b) The board shall issue a graduate assistant physician limited license for a duration of 2 years to an applicant who meets the requirements of paragraph (a) and all of the following criteria:

1. Is at least 21 years of age.

2. Is of good moral character.

3. Submits documentation that the applicant has agreed to enter into a written protocol drafted by a physician with a full, active, and unencumbered license issued under this chapter upon the board's issuance of a limited license to the applicant and submits a copy of the protocol. The board shall establish by rule specific provisions that must be included in a physician-drafted protocol.

4. Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331.

5. Has submitted to the department a set of fingerprints on a form and under procedures specified by the department.

6. The board may not certify to the department for limited licensure under this subsection any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter or chapter 456 until such investigation is completed. Upon completion of the investigation, s. 458.331 applies. Furthermore, the department may not issue a limited license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 458.331. If the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 458.331, the board may enter an order imposing one of the following terms:

a. Refusal to certify to the department an application for a graduate assistant physician limited license; or

b. Certification to the department of an application for a graduate assistant physician limited license with restrictions on the scope of practice of the licensee.

(c) A graduate assistant physician limited licensee may apply for a one-time renewal of his or her limited license by submitting a board-approved application, documentation of actual practice under the required protocol during the initial limited licensure period, and documentation of applications he or she has submitted for accredited graduate medical education training programs. The one-time renewal terminates after 1 year.

(d) A limited licensed graduate assistant physician may provide health care services only under the direct supervision of a physician with a full, active, and unencumbered license issued under this chapter.

(e) A physician must be approved by the board to supervise a limited licensed graduate assistant physician.

(f) A physician may supervise no more than two graduate assistant physicians with limited licenses.

(g) Supervision of limited licensed graduate assistant physicians requires the physical presence of the supervising physician at the location where the services are rendered.

(h) A physician-drafted protocol must specify the duties and responsibilities of the limited licensed graduate assistant physician according to criteria adopted by board rule.

(i) Each protocol that applies to a limited licensed graduate assistant physician and his or her supervising physician must ensure that:

1. There is a process for the evaluation of the limited licensed graduate assistant physicians' performance; and

2. The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate assistant physician's level of competency.

(j) A limited licensed graduate assistant physician's prescriptive authority is governed by the physician-drafted

protocol and criteria adopted by the board and may not exceed that of his or her supervising physician. Any prescriptions and orders issued by the graduate assistant physician must identify both the graduate assistant physician and the supervising physician.

(k) A physician who supervises a graduate assistant physician is liable for any acts or omissions of the graduate assistant physician acting under the physician's supervision and control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate assistant physicians.

(3) RULES.—The board may adopt rules to implement this section.

Section 51. Section 459.0075, Florida Statutes, is amended to read:

459.0075 Limited licenses.—

(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS.—

(a) Any person desiring to obtain a limited license under this subsection must ~~shall~~:

1.~~(a)~~ Submit to the board a licensure application and fee required by this chapter. However, an osteopathic physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that she or he will not receive

monetary compensation for any service involving the practice of osteopathic medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license must ~~shall~~ pay such fees if the person receives compensation for the practice of osteopathic medicine.

2.~~(b)~~ Submit proof that such osteopathic physician has been licensed to practice osteopathic medicine in any jurisdiction in the United States in good standing and pursuant to law for at least 10 years.

3.~~(c)~~ Complete an amount of continuing education established by the board.

(b)~~(2)~~ If it has been more than 3 years since active practice was conducted by the applicant, the full-time director of the local county health department must ~~shall~~ supervise the applicant for a period of 6 months after the applicant is granted a limited license under this subsection ~~to practice~~, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure under this subsection ~~pursuant to this section~~. Procedures for such supervision must ~~shall~~ be established by the board.

(c)~~(3)~~ The recipient of a limited license under this subsection may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the

requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in areas of critical medical need or in medically underserved areas as determined pursuant to 42 U.S.C. s. 300e-1(7).

(d) ~~(4)~~ The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under the provisions of this subsection ~~section~~. The director of the full-time county health department shall assist in the supervision of any licensee within the ~~her or his~~ county and shall notify the board if she or he becomes aware of any action by the licensee which would be a ground for revocation of the limited license. The board shall establish procedures for such supervision.

(e) ~~(5)~~ The ~~State~~ board ~~of Osteopathic Medicine~~ shall review the practice of each licensee under this subsection ~~section~~ biennially to verify compliance with the restrictions prescribed in this subsection ~~section~~ and other provisions of this chapter.

(f) ~~(6)~~ Any person holding an active license to practice osteopathic medicine in this ~~the~~ state may convert that license to a limited license under this subsection for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that she or he ~~or she~~ will not receive compensation for any service involving the

practice of osteopathic medicine. The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for such applicant.

(2) GRADUATE ASSISTANT PHYSICIANS.— A graduate assistant physician is a medical school graduate who meets the requirements of this subsection and has obtained a limited license from the board for the purpose of practicing temporarily under the direct supervision of a physician who has a full, active, and unencumbered license issued under this chapter, pending the graduate's entrance into a residency under the National Resident Match Program.

(a) Any person desiring to obtain a limited license as a graduate assistant physician must submit to the board an application and demonstrate that she or he meets all of the following criteria:

1. Is a graduate of a school or college of osteopathic medicine approved by an accrediting agency recognized by the United States Department of Education.

2. Has successfully passed all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board.

3. Has not received and accepted a residency match from the National Resident Matching Program within the first year following graduation from medical school.

(b) The board shall issue a graduate assistant physician

limited license for a duration of 2 years to an applicant who meets the requirements of paragraph (a) and all of the following criteria:

1. Is at least 21 years of age.

2. Is of good moral character.

3. Submits documentation that the applicant has agreed to enter into a written protocol drafted by a physician with a full, active, and unencumbered license issued under this chapter upon the board's issuance of a limited license to the applicant, and submits a copy of the protocol. The board shall establish by rule specific provisions that must be included in a physician-drafted protocol.

4. Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 459.015.

5. Has submitted to the department a set of fingerprints on a form and under procedures specified by the department.

6. The board may not certify to the department for limited licensure under this subsection any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter or chapter 456 until such investigation is completed. Upon completion of the investigation, s. 459.015 applies. Furthermore, the department may not issue a limited license to any individual who has committed any act or offense in any jurisdiction which would

constitute the basis for disciplining a physician under s. 459.015. If the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 459.015, the board may enter an order imposing one of the following terms:

a. Refusal to certify to the department an application for a graduate assistant physician limited license; or

b. Certification to the department of an application for a graduate assistant physician limited license with restrictions on the scope of practice of the licensee.

(c) A graduate assistant physician limited licensee may apply for a one-time renewal of his or her limited license by submitting a board-approved application, documentation of actual practice under the required protocol during the initial limited licensure period, and documentation of applications he or she has submitted for accredited graduate medical education training programs. The one-time renewal terminates after 1 year.

(d) A limited licensed graduate assistant physician may provide health care services only under the direct supervision of a physician with a full, active, and unencumbered license issued under this chapter.

(e) A physician must be approved by the board to supervise a limited licensed graduate assistant physician.

(f) A physician may supervise no more than two graduate assistant physicians with limited licenses.

(g) Supervision of limited licensed graduate assistant physicians requires the physical presence of the supervising physician at the location where the services are rendered.

(h) A physician-drafted protocol must specify the duties and responsibilities of the limited licensed graduate assistant physician according to criteria adopted by board rule.

(i) Each protocol that applies to a limited licensed graduate assistant physician and his or her supervising physician must ensure that:

1. There is a process for the evaluation of the limited licensed graduate assistant physicians' performance; and

2. The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate assistant physician's level of competency.

(j) A limited licensed graduate assistant physician's prescriptive authority is governed by the physician-drafted protocol and criteria adopted by the board and may not exceed that of his or her supervising physician. Any prescriptions and orders issued by the graduate assistant physician must identify both the graduate assistant physician and the supervising physician.

(k) A physician who supervises a graduate assistant physician is liable for any acts or omissions of the graduate assistant physician acting under the physician's supervision and

control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate assistant physicians.

(3) RULES.—The board may adopt rules to implement this section.

Section 52. Section 459.0076, Florida Statutes, is amended to read:

459.0076 Temporary certificate for practice in areas of critical need.—

(1) A physician or physician assistant who holds a valid license ~~is licensed~~ to practice in any jurisdiction of the United States~~, whose license is currently valid, and who pays an application fee of $300~~ may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300.

(2) A temporary certificate may be issued under this section to a physician or physician assistant who will:

(a) ~~Will~~ Practice in an area of critical need;

(b) ~~Will~~ Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state; or

(c) ~~Will~~ Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The board ~~of Osteopathic Medicine~~ may issue a ~~this~~ temporary certificate subject to ~~with~~ the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.

(b) The board may administer an abbreviated oral examination to determine the physician's or physician assistant's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application

and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application ~~prior 3 years~~ and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The board ~~of Osteopathic Medicine~~ shall review each temporary certificateholder at least ~~not less than~~ annually to

ascertain that the certificateholder is complying with the minimum requirements of the Osteopathic Medical Practice Act and its adopted rules, as applicable to the certificateholder ~~are being complied with~~. If it is determined that the certificateholder is not meeting such minimum requirements ~~are not being met~~, the board must ~~shall~~ revoke such certificate or ~~shall~~ impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician or physician assistant who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time ~~the provisions of~~ s. 459.015 applies ~~apply~~.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the physician or physician assistant will not receive any compensation for any health care services that he or she provides ~~service involving the practice of medicine~~.

Section 53. Section 464.009, Florida Statutes, is amended to read:

464.009 Licensure by endorsement.—

~~(1)~~ The department shall issue the appropriate license by endorsement to practice professional or practical nursing to an applicant who, upon applying to the department and remitting a fee set by the board not to exceed $100, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Holds a valid license to practice professional or practical nursing in another state or territory of the United States, provided that, when the applicant secured his or her original license, the requirements for licensure were substantially equivalent to or more stringent than those existing in Florida at that time;~~

~~(b) Meets the qualifications for licensure in s. 464.008 and has successfully completed a state, regional, or national examination which is substantially equivalent to or more stringent than the examination given by the department; or~~

~~(c) Has actively practiced nursing in another state, jurisdiction, or territory of the United States for 2 of the preceding 3 years without having his or her license acted against by the licensing authority of any jurisdiction. Applicants who become licensed pursuant to this paragraph must complete within 6 months after licensure a Florida laws and~~

~~rules course that is approved by the board. Once the department has received the results of the national criminal history check and has determined that the applicant has no criminal history, the appropriate license by endorsement shall be issued to the applicant.~~

~~(2) Such examinations and requirements from other states and territories of the United States shall be presumed to be substantially equivalent to or more stringent than those in this state. Such presumption shall not arise until January 1, 1980. However, the board may, by rule, specify states and territories the examinations and requirements of which shall not be presumed to be substantially equivalent to those of this state.~~

~~(3) An applicant for licensure by endorsement who is relocating to this state pursuant to his or her military-connected spouse's official military orders and who is licensed in another state that is a member of the Nurse Licensure Compact shall be deemed to have satisfied the requirements of subsection (1) and shall be issued a license by endorsement upon submission of the appropriate application and fees and completion of the criminal background check required under subsection (4).~~

~~(4) The applicant must submit to the department a set of fingerprints on a form and under procedures specified by the department, along with a payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant. The Department of Health shall submit~~

~~the fingerprints provided by the applicant to the Florida Department of Law Enforcement for a statewide criminal history check, and the Florida Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history check of the applicant. The Department of Health shall review the results of the criminal history check, issue a license to an applicant who has met all of the other requirements for licensure and has no criminal history, and shall refer all applicants with criminal histories back to the board for determination as to whether a license should be issued and under what conditions.~~

~~(5) The department shall not issue a license by endorsement to any applicant who is under investigation in another state, jurisdiction, or territory of the United States for an act which would constitute a violation of this part or chapter 456 until such time as the investigation is complete, at which time the provisions of s. 464.018 shall apply.~~

~~(6) The department shall develop an electronic applicant notification process and provide electronic notification when the application has been received and when background screenings have been completed, and shall issue a license within 30 days after completion of all required data collection and verification. This 30-day period to issue a license shall be tolled if the applicant must appear before the board due to information provided on the application or obtained through~~

~~screening and data collection and verification procedures.~~

~~(7) A person holding an active multistate license in another state pursuant to s. 464.0095 is exempt from the requirements for licensure by endorsement in this section.~~

Section 54. Section 464.0121, Florida Statutes, is created to read:

464.0121 Temporary certificate for practice in areas of critical need.—

(1) An advanced practice registered nurse who is licensed to practice in any jurisdiction of the United States, whose license is currently valid, and who meets educational and training requirements established by the board may be issued a temporary certificate for practice in areas of critical need.

(2) A temporary certificate may be issued under this section to an advanced practice registered nurse who will:

(a) Practice in an area of critical need;

(b) Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or another agency or institution that is approved by the State Surgeon General and that provides health care services to meet the needs of underserved populations in this state; or

(c) Practice for a limited time to address critical health care specialty, demographic, or geographic needs relating to

this state's accessibility of health care services as determined by the State Surgeon General.

(3) The board may issue a temporary certificate under this section subject to the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices as part of his or her employment.

(b) The board may administer an abbreviated oral examination to determine the advanced practice registered nurse's competency, but may not require a written regular examination. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant

has not actively practiced during the 3-year period immediately preceding the application and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate imposing reasonable restrictions that may include, but are not limited to, a requirement that the applicant practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board, which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General maintains the determination that the critical need that supported the issuance of the temporary certificate remains a critical need to the state. The board shall review each temporary certificateholder at least annually to ascertain that the certificateholder is complying with the minimum requirements of the Nurse Practice Act and its adopted rules, as applicable to the certificateholder. If it is determined that the certificateholder is not meeting such minimum requirements, the

board must revoke such certificate or impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any advanced practice registered nurse who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this part until such time as the investigation is complete, at which time s. 464.018 applies.

(4) All licensure fees, including neurological injury compensation assessments, are waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the advanced practice registered nurse will not receive any compensation for any health care services that he or she provides.

Section 55. Paragraph (b) of subsection (3) of section 464.0123, Florida Statutes, is amended to read:

464.0123 Autonomous practice by an advanced practice registered nurse.—

(3) PRACTICE REQUIREMENTS.—

(b)1. In order to provide out-of-hospital intrapartum care, a certified nurse midwife engaged in the autonomous

practice of nurse midwifery must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The policy must prescribe and require the use of an emergency plan-of-care form, which must be signed by the patient before admission to intrapartum care. At a minimum, the form must include all of the following:

a. The name and address of the closest hospital that provides maternity and newborn services.

b. Reasons for which transfer of care would be necessary, including the transfer-of-care conditions prescribed by board rule.

c. Ambulances or other emergency medical services that would be used to transport the patient in the event of an emergency.

2. If transfer of care is determined necessary by the certified nurse midwife or under the terms of the written policy, the certified nurse midwife must document all of the following information on the patient's emergency plan-of-care form:

a. The name, date of birth, and condition of the patient.

b. The gravidity and parity of the patient and the gestational age and condition of the fetus or newborn infant.

c. The reasons that necessitated the transfer of care.

d. A description of the situation, relevant clinical background, assessment, and recommendations.

e. The planned mode of transporting the patient to the receiving facility.

f. The expected time of arrival at the receiving facility.

3. Before transferring the patient, or as soon as possible during or after an emergency transfer, the certified nurse midwife shall provide the receiving provider with a verbal summary of the information specified in subparagraph 2. and make himself or herself immediately available for consultation. Upon transfer of the patient to the receiving facility, the certified nurse midwife must provide the receiving provider with the patient's emergency plan-of-care form as soon as practicable.

4. The certified nurse midwife shall provide the receiving provider, as soon as practicable, with the patient's prenatal records, including patient history, prenatal laboratory results, sonograms, prenatal care flow sheets, maternal fetal medical reports, and labor flow charting and current notations.

5. The board shall adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the licensure of certified nurse midwives engaged in autonomous practice ~~must have a written patient transfer agreement with a hospital and a written referral agreement with a physician licensed under chapter 458 or chapter 459 to engage in nurse midwifery~~.

Section 56. Subsection (10) of section 464.019, Florida

Statutes, is amended to read:

464.019 Approval of nursing education programs.—

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30~~, through January 30, 2025~~. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing.

(a) The Florida Center for Nursing shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

1. The number of programs and student slots available.

2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

3. The number of program graduates.

4. Program retention rates of students tracked from program entry to graduation.

5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.

6. The number of graduates who become employed as practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board's implementation of the:

1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1), the number of program applications approved and denied by the board under subsection (2), the number of denials of program applications reviewed under chapter 120, and a description of the outcomes of those reviews.

2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the reports required by this subsection.

Section 57. Section 465.0075, Florida Statutes, is amended to read:

465.0075 Licensure by endorsement; requirements; fee.—

~~(1)~~ The department shall issue a license by endorsement to any applicant who applies to the department and remits a nonrefundable fee of not more than $100, as set by the board, and whom the board certifies has met the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Has met the qualifications for licensure in s. 465.007(1)(b) and (c);~~

~~(b) Has obtained a passing score, as established by rule of the board, on the licensure examination of the National Association of Boards of Pharmacy or a similar nationally recognized examination, if the board certifies that the applicant has taken the required examination;~~

~~(c)1. Has submitted evidence of the active licensed practice of pharmacy, including practice in community or public health by persons employed by a governmental entity, in another jurisdiction for at least 2 of the immediately preceding 5 years or evidence of successful completion of board-approved postgraduate training or a board-approved clinical competency examination within the year immediately preceding application for licensure; or~~

~~2. Has completed an internship meeting the requirements of s. 465.007(1)(c) within the 2 years immediately preceding~~

~~application; and~~

~~(d) Has obtained a passing score on the pharmacy jurisprudence portions of the licensure examination, as required by board rule.~~

~~(2) An applicant licensed in another state for a period in excess of 2 years from the date of application for licensure in this state shall submit a total of at least 30 hours of board-approved continuing education for the 2 calendar years immediately preceding application.~~

~~(3) The department may not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense that would constitute a violation of this chapter until the investigation is complete, at which time the provisions of s. 465.016 apply.~~

~~(4) The department may not issue a license by endorsement to any applicant whose license to practice pharmacy has been suspended or revoked in another state or who is currently the subject of any disciplinary proceeding in another state.~~

Section 58. Subsection (1) of section 467.0125, Florida Statutes, is amended to read:

467.0125 Licensed midwives; qualifications; endorsement; temporary certificates.—

(1) The department shall issue a license by endorsement to practice midwifery to an applicant who~~, upon applying to the department,~~ demonstrates to the department that she or he meets

~~all of~~ the requirements for licensure by endorsement in s. 456.0145 and submits ~~following criteria:~~

~~(a) Holds an active, unencumbered license to practice midwifery in another state, jurisdiction, or territory, provided the licensing requirements of that state, jurisdiction, or territory at the time the license was issued were substantially equivalent to or exceeded those established under this chapter and the rules adopted hereunder.~~

~~(b) Has successfully completed a prelicensure course conducted by an accredited and approved midwifery program.~~

~~(c) Submits~~ an application for licensure on a form approved by the department and pays the appropriate fee.

Section 59. Subsection (4) of section 468.1705, Florida Statutes, is renumbered as subsection (3) and subsections (1), (2), and (3) of that section are amended, to read:

468.1705 Licensure by endorsement; temporary license.—

(1) The department shall issue a license by endorsement to any applicant who, upon applying to the department and remitting a fee set by the board not to exceed $500, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145~~:~~

~~(a) Meets one of the following requirements:~~

~~1. Holds a valid active license to practice nursing home administration in another state of the United States, provided that the current requirements for licensure in that state are~~

~~substantially equivalent to, or more stringent than, current requirements in this state; or~~

~~2. Meets the qualifications for licensure in s. 468.1695;~~ ~~and~~

~~(b)1. Has successfully completed a national examination which is substantially equivalent to, or more stringent than, the examination given by the department;~~

~~2. Has passed an examination on the laws and rules of this state governing the administration of nursing homes; and~~

~~3. Has worked as a fully licensed nursing home administrator for 2 years within the 5-year period immediately preceding the application by endorsement.~~

~~(2) National examinations for licensure as a nursing home administrator shall be presumed to be substantially equivalent to, or more stringent than, the examination and requirements in this state, unless found otherwise by rule of the board~~.

(2)~~(3)~~ The department may ~~shall~~ not issue a ~~license by endorsement or a~~ temporary license to any applicant who is under investigation in this or another state for any act which would constitute a violation of this part until such time as the investigation is complete and disciplinary proceedings have been terminated.

Section 60. Section 468.213, Florida Statutes, is repealed.

Section 61. Section 468.3065, Florida Statutes, is amended

to read:

468.3065 Certification by endorsement.—

(1) The department may issue a certificate by endorsement to practice as a radiologist assistant to an applicant who, upon applying to the department and remitting a nonrefundable fee not to exceed $50, demonstrates to the department that he or she meets the requirements for licensure by endorsement in s. 456.0145 ~~holds a current certificate or registration as a radiologist assistant granted by the American Registry of Radiologic Technologists~~.

(2) The department may issue a certificate by endorsement to practice radiologic technology to an applicant who, upon applying to the department and remitting a nonrefundable fee not to exceed $50, demonstrates to the department that he or she meets the requirements for licensure by endorsement in s. 456.0145 ~~holds a current certificate, license, or registration to practice radiologic technology, provided that the requirements for such certificate, license, or registration are deemed by the department to be substantially equivalent to those established under this part and rules adopted under this part~~.

(3) The department may issue a certificate by endorsement to practice as a specialty technologist to an applicant who, upon applying to the department and remitting a nonrefundable fee not to exceed $100, demonstrates to the department that he or she meets the requirements for licensure by endorsement in s.

456.0145 ~~holds a current certificate or registration from a national organization in a particular advanced, postprimary, or specialty area of radiologic technology, such as computed tomography or positron emission tomography~~.

Section 62. Section 468.358, Florida Statutes, is repealed.

Section 63. Section 478.47, Florida Statutes, is amended to read:

478.47 Licensure by endorsement.—The department shall issue a license by endorsement to any applicant who, upon submitting ~~submits~~ an application and the required fees as set forth in s. 478.55, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145 ~~and who holds an active license or other authority to practice electrology in a jurisdiction whose licensure requirements are determined by the board to be equivalent to the requirements for licensure in this state~~.

Section 64. Paragraph (c) of subsection (5) of section 480.041, Florida Statutes, is amended to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(5) The board shall adopt rules:

(c) Specifying licensing procedures for practitioners desiring to be licensed in this state who meet the requirements for licensure by endorsement in section 456.0145 or hold an

active license and have practiced in ~~any other state, territory, or jurisdiction of the United States or~~ any foreign national jurisdiction which has licensing standards substantially similar to, equivalent to, or more stringent than the standards of this state.

Section 65. Section 486.081, Florida Statutes, is amended to read:

486.081 Physical therapist; endorsement; ~~issuance of license without examination to person passing examination of another authorized examining board; fee~~.—

(1) The board may cause a license by endorsement to be issued through the department ~~without examination~~ to any applicant who presents evidence satisfactory to the board of meeting the requirements for licensure by endorsement in s. 456.0145 ~~having passed the American Registry Examination prior to 1971 or an examination in physical therapy before a similar lawfully authorized examining board of another state, the District of Columbia, a territory, or a foreign country, if the standards for licensure in physical therapy in such other state, district, territory, or foreign country are determined by the board to be as high as those of this state, as established by rules adopted pursuant to this chapter~~. Any person who holds a license pursuant to this section may use the words "physical therapist" or "physiotherapist" or the letters "P.T." in connection with her or his name or place of business to denote

her or his licensure hereunder. A person who holds a license pursuant to this section and obtains a doctoral degree in physical therapy may use the letters "D.P.T." and "P.T." A physical therapist who holds a degree of Doctor of Physical Therapy may not use the title "doctor" without also clearly informing the public of his or her profession as a physical therapist.

(2) At the time of making application for licensure by endorsement under ~~without examination pursuant to the terms of~~ this section, the applicant shall pay to the department a fee not to exceed $175 as fixed by the board, no part of which will be returned.

Section 66. Section 491.006, Florida Statutes, is amended to read:

491.006 Licensure or certification by endorsement.—

(1) The department shall license or grant a certificate to a person in a profession regulated by this chapter who, upon applying to the department and remitting the appropriate fee, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145~~:~~

~~(a) Has demonstrated, in a manner designated by rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.~~

~~(b)1. Holds an active valid license to practice and has~~

~~actively practiced the licensed profession in another state for 3 of the last 5 years immediately preceding licensure;~~

~~2. Has passed a substantially equivalent licensing examination in another state or has passed the licensure examination in this state in the profession for which the applicant seeks licensure; and~~

~~3. Holds a license in good standing, is not under investigation for an act that would constitute a violation of this chapter, and has not been found to have committed any act that would constitute a violation of this chapter~~.

The fees paid by any applicant for certification as a master social worker under this section are nonrefundable.

~~(2) The department shall not issue a license or certificate by endorsement to any applicant who is under investigation in this or another jurisdiction for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 491.009 shall apply.~~

(2)~~(3)~~ A person licensed as a clinical social worker, marriage and family therapist, or mental health counselor in another state who is practicing under the Professional Counselors Licensure Compact pursuant to s. 491.017, and only within the scope provided therein, is exempt from the licensure requirements of this section, as applicable.

Section 67. Section 458.3129, Florida Statutes, is created to read:

458.3129 Interstate Medical Licensure Compact.—A physician licensed to practice allopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 68. Section 459.074, Florida Statutes, is created to read:

459.074 Interstate Medical Licensure Compact.—A physician licensed to practice osteopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 69. Subsections (4), (5), and (6) of section 468.1135, Florida Statutes, are renumbered as subsections (5), (6), and (7), respectively, and a new subsection (4) is added to that section, to read:

468.1135 Board of Speech-Language Pathology and Audiology.—

(4) The board shall appoint two of its members to serve as the state's delegates on the Speech-Language Pathology Interstate Compact Commission, pursuant to s. 468.1335, one of whom must be an audiologist and one of whom must be a speech-language pathologist.

Section 70. Subsection (5) section 468.1185, Florida Statutes, is renumbered as subsection (3), subsections (3) and (4) are amended, and a new subsection (4) is added to that section, to read:

468.1185 Licensure.—

~~(3) The board shall certify as qualified for a license by endorsement as a speech-language pathologist or audiologist an applicant who:~~

~~(a) Holds a valid license or certificate in another state or territory of the United States to practice the profession for which the application for licensure is made, if the criteria for issuance of such license were substantially equivalent to or more stringent than the licensure criteria which existed in this state at the time the license was issued; or~~

~~(b) Holds a valid certificate of clinical competence of the American Speech-Language and Hearing Association or board certification in audiology from the American Board of Audiology.~~

(4) A person licensed as an audiologist or a speech-language pathologist in another state who is practicing under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335, and only within the scope provided therein, is exempt from the licensure requirements of this section.

~~(4) The board may refuse to certify any applicant who is under investigation in any jurisdiction for an act which would constitute a violation of this part or chapter 456 until the investigation is complete and disciplinary proceedings have been terminated.~~

Section 71. Subsections (1) and (2) of section 468.1295,

Florida Statutes, are amended to read:

468.1295 Disciplinary proceedings.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 468.1335:

(a) Procuring, or attempting to procure, a license by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(b) Having a license revoked, suspended, or otherwise acted against, including denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of speech-language pathology or audiology.

(d) Making or filing a report or record which the licensee knows to be false, intentionally or negligently failing to file a report or records required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such report or record shall include only those reports or records which are signed in one's capacity as a licensed speech-language pathologist or audiologist.

(e) Advertising goods or services in a manner which is fraudulent, false, deceptive, or misleading in form or content.

(f) Being proven guilty of fraud or deceit or of negligence, incompetency, or misconduct in the practice of speech-language pathology or audiology.

(g) Violating a lawful order of the board or department previously entered in a disciplinary hearing, or failing to comply with a lawfully issued subpoena of the board or department.

(h) Practicing with a revoked, suspended, inactive, or delinquent license.

(i) Using, or causing or promoting the use of, any advertising matter, promotional literature, testimonial, guarantee, warranty, label, brand, insignia, or other representation, however disseminated or published, which is misleading, deceiving, or untruthful.

(j) Showing or demonstrating or, in the event of sale, delivery of a product unusable or impractical for the purpose represented or implied by such action.

(k) Failing to submit to the board on an annual basis, or such other basis as may be provided by rule, certification of testing and calibration of such equipment as designated by the board and on the form approved by the board.

(l) Aiding, assisting, procuring, employing, or advising any licensee or business entity to practice speech-language pathology or audiology contrary to this part, chapter 456, or any rule adopted pursuant thereto.

(m) Misrepresenting the professional services available in the fitting, sale, adjustment, service, or repair of a hearing aid, or using any other term or title which might connote the availability of professional services when such use is not accurate.

(n) Representing, advertising, or implying that a hearing aid or its repair is guaranteed without providing full disclosure of the identity of the guarantor; the nature, extent, and duration of the guarantee; and the existence of conditions or limitations imposed upon the guarantee.

(o) Representing, directly or by implication, that a hearing aid utilizing bone conduction has certain specified features, such as the absence of anything in the ear or leading to the ear, or the like, without disclosing clearly and conspicuously that the instrument operates on the bone conduction principle and that in many cases of hearing loss this type of instrument may not be suitable.

(p) Stating or implying that the use of any hearing aid will improve or preserve hearing or prevent or retard the progression of a hearing impairment or that it will have any similar or opposite effect.

(q) Making any statement regarding the cure of the cause of a hearing impairment by the use of a hearing aid.

(r) Representing or implying that a hearing aid is or will be "custom-made," "made to order," or "prescription-made," or in

any other sense specially fabricated for an individual, when such is not the case.

(s) Canvassing from house to house or by telephone, either in person or by an agent, for the purpose of selling a hearing aid, except that contacting persons who have evidenced an interest in hearing aids, or have been referred as in need of hearing aids, shall not be considered canvassing.

(t) Failing to notify the department in writing of a change in current mailing and place-of-practice address within 30 days after such change.

(u) Failing to provide all information as described in ss. 468.1225(5)(b), 468.1245(1), and 468.1246.

(v) Exercising influence on a client in such a manner as to exploit the client for financial gain of the licensee or of a third party.

(w) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee or certificateholder knows, or has reason to know, the licensee or certificateholder is not competent to perform.

(x) Aiding, assisting, procuring, or employing any unlicensed person to practice speech-language pathology or audiology.

(y) Delegating or contracting for the performance of professional responsibilities by a person when the licensee

delegating or contracting for performance of such responsibilities knows, or has reason to know, such person is not qualified by training, experience, and authorization to perform them.

(z) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined pursuant to s. 468.1296.

(aa) Being unable to practice the profession for which he or she is licensed or certified under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness, drunkenness, or use of drugs, narcotics, chemicals, or any other substance. In enforcing this paragraph, upon a finding by the State Surgeon General, his or her designee, or the board that probable cause exists to believe that the licensee or certificateholder is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee or certificateholder to submit to a mental or physical examination by a physician, psychologist, clinical social worker, marriage and family therapist, or mental health counselor designated by the department or board. If the licensee or certificateholder refuses to comply with the department's order directing the examination, such order may be enforced by filing a petition for enforcement in the circuit court in the circuit in which the licensee or certificateholder resides or

does business. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice for which he or she is licensed or certified with reasonable skill and safety to patients.

(bb) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(b) The board may take adverse action against an audiologist's or a speech-language pathologist's compact privilege under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335 and may impose any of the penalties in s. 456.072(2), if an audiologist or a speech-language pathologist commits an act specified in subsection (1) or s. 456.072(1).

Section 72. Section 468.1335, Florida Statutes, is created to read:

468.1335 Practice of Audiology and Speech-language Pathology Interstate Compact.—The Practice of Audiology and Speech-language Pathology Interstate Compact is hereby enacted

into law and entered into by this state with all other states legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE

(1) The purpose of the compact is to facilitate the interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services.

(2) The practice of audiology and speech-language pathology occurs in the state where the patient, client, or student is located at the time the services are provided.

(3) The compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

(4) The compact is designed to achieve all of the following objectives:

(a) Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' abilities to protect public health and safety.

(c) Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology

practices.

(d) Support spouses of relocating active duty military personnel.

(e) Enhance the exchange of licensure, investigative, and disciplinary information between member states.

(f) Allow a remote state to hold a licensee with compact privilege in that state accountable to that state's practice standards.

(g) Allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services.

ARTICLE II

DEFINITIONS

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

(2) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapters 1209 and 1211.

(3) "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board against a licensee, including actions against an individual's license or privilege to practice such as revocation, suspension, probation, monitoring of the

licensee, or restriction on the licensee's practice.

(4) "Alternative program" means a nondisciplinary monitoring process approved by an audiology licensing board or a speech-language pathology licensing board to address impaired licensees.

(5) "Audiologist" means an individual who is licensed by a state to practice audiology.

(6) "Audiology" means the care and services provided by a licensed audiologist as provided in the member state's rules and regulations.

(7) "Audiology and Speech-language Pathology Interstate Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(8) "Audiology licensing board" means the agency of a state that is responsible for the licensing and regulation of audiologists.

(9) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its rules and regulations. The practice of audiology or speech-language pathology occurs in the member state where the patient, client, or student is located at the time the services are provided.

(10) "Current significant investigative information,"

"investigative materials," "investigative records," or "investigative reports" means information that a licensing board, after an inquiry or investigation that includes notification and an opportunity for the audiologist or speech-language pathologist to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.

(11) "Data system" means a repository of information relating to licensees, including, but not limited to, continuing education, examination, licensure, investigative, compact privilege, and adverse action information.

(12) "Encumbered license" means a license in which an adverse action restricts the practice of audiology or speech-language pathology by the licensee and the adverse action has been reported to the National Practitioner Data Bank (NPDB).

(13) "Executive committee" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(14) "Home state" means the member state that is the licensee's primary state of residence.

(15) "Impaired licensee" means a licensee whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions.

(16) "Licensee" means a person who is licensed by his or her home state to practice as an audiologist or speech-language

pathologist.

(17) "Licensing board" means the agency of a state that is responsible for the licensing and regulation of audiologists or speech-language pathologists.

(18) "Member state" means a state that has enacted the compact.

(19) "Privilege to practice" means the legal authorization to practice audiology or speech-language pathology in a remote state.

(20) "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise his or her compact privilege.

(21) "Rule" means a regulation, principle, or directive adopted by the commission that has the force of law.

(22) "Single-state license" means an audiology or speech-language pathology license issued by a member state that authorizes practice only within the issuing state and does not include a privilege to practice in any other member state.

(23) "Speech-language pathologist" means an individual who is licensed to practice speech-language pathology.

(24) "Speech-language pathology" means the care and services provided by a licensed speech-language pathologist as provided in the member state's rules and regulations.

(25) "Speech-language pathology licensing board" means the agency of a state that is responsible for the licensing and

regulation of speech-language pathologists.

(26) "State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of audiology and speech-language pathology.

(27) "State practice laws" means a member state's laws, rules, and regulations that govern the practice of audiology or speech-language pathology, define the scope of audiology or speech-language pathology practice, and create the methods and grounds for imposing discipline.

(28) "Telehealth" means the application of telecommunication technology to deliver audiology or speech-language pathology services at a distance for assessment, intervention, or consultation.

ARTICLE III

STATE PARTICIPATION

(1) A license issued to an audiologist or speech-language pathologist by a home state to a resident in that state must be recognized by each member state as authorizing an audiologist or speech-language pathologist to practice audiology or speech-language pathology, under a privilege to practice, in each member state.

(2) A state must implement procedures for considering the criminal history records of applicants for initial privilege to

practice. These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history records from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal history records.

(a) A member state must fully implement a criminal history records check procedure, within a timeframe established by rule, which requires the member state to receive an applicant's criminal history records from the Federal Bureau of Investigation and the agency responsible for retaining the member state's criminal history records and use such records in making licensure decisions.

(b) Communication between a member state, the commission, and other member states regarding the verification of eligibility for licensure through the compact may not include any information received from the Federal Bureau of Investigation relating to a criminal history records check performed by a member state under Pub. L. No. 92-544.

(3) Upon application for a privilege to practice, the licensing board in the issuing remote state must determine, through the data system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or privilege to practice held by the applicant, and whether any adverse action has been taken against any license or privilege to practice held

by the applicant.

(4) Each member state must require an applicant to obtain or retain a license in his or her home state and meet the home state's qualifications for licensure or renewal of licensure and all other applicable state laws.

(5) Each member state must require that an applicant meet all of the following criteria to receive the privilege to practice as an audiologist in the member state:

(a) One of the following educational requirements:

1. On or before December 31, 2007, has graduated with a master's degree or doctoral degree in audiology, or an equivalent degree, regardless of the name of such degree, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

2. On or after January 1, 2008, has graduated with a doctoral degree in audiology, or an equivalent degree, regardless of the name of such degree, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

3. Has graduated from an audiology program that is housed in an institution of higher education outside of the United States for which the degree program and institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.

(b) Has completed a supervised clinical practicum experience from an accredited educational institution or its cooperating programs as required by the commission.

(c) Has successfully passed a national examination approved by the commission.

(d) Holds an active, unencumbered license.

(e) Has not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.

(f) Has a valid United States social security number or a national provider identifier number.

(6) Each member state must require that an applicant meet all of the following criteria to receive the privilege to practice as a speech-language pathologist in the member state:

(a) One of the following educational requirements:

1. Has graduated with a master's degree from a speech-

language pathology program that is accredited by an organization recognized by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

2. Has graduated from a speech-language pathology program that is housed in an institution of higher education outside of the United States for which the degree program and institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.

(b) Has completed a supervised clinical practicum experience from an educational institution or its cooperating programs as required by the commission.

(c) Has completed a supervised postgraduate professional experience as required by the commission.

(d) Has successfully passed a national examination approved by the commission.

(e) Holds an active, unencumbered license.

(f) Has not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.

(g) Has a valid United States social security number or

national provider identifier number.

(7) The privilege to practice is derived from the home state license.

(8) An audiologist or speech-language pathologist practicing in a member state must comply with the state practice laws of the member state where the client is located at the time service is provided. The practice of audiology and speech-language pathology includes all audiology and speech-language pathology practices as defined by the state practice laws of the member state where the client is located. The practice of audiology and speech-language pathology in a member state under a privilege to practice subjects an audiologist or speech-language pathologist to the jurisdiction of the licensing boards, courts, and laws of the member state where the client is located at the time service is provided.

(9) Individuals not residing in a member state shall continue to be able to apply for a member state's single-state license as provided under the laws of each member state. However, the single-state license granted to these individuals may not be recognized as granting the privilege to practice audiology or speech-language pathology in any other member state. The compact does not affect the requirements established by a member state for the issuance of a single-state license.

(10) Member states may charge a fee for granting a compact privilege.

(11) Member states must comply with the bylaws and rules of the commission.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise compact privilege under the compact, the audiologist or speech-language pathologist must meet all of the following criteria:

(a) Hold an active license in the home state.

(b) Have no encumbrance on any state license.

(c) Be eligible for compact privilege in any member state in accordance with Article III.

(d) Not have any adverse action against any license or compact privilege within the 2 years preceding the date of application.

(e) Notify the commission that he or she is seeking compact privilege within a remote state or states.

(f) Pay any applicable fees, including any state fee, for the compact privilege.

(g) Report to the commission any adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) For the purposes of compact privilege, an audiologist or speech-language pathologist may only hold one home state

license at a time.

(3) Except as provided in Article VI, if an audiologist or speech-language pathologist changes his or her primary state of residence by moving between two member states, the audiologist or speech-language pathologist must apply for licensure in the new home state, and the license issued by the prior home state shall be deactivated in accordance with applicable rules adopted by the commission.

(4) The audiologist or speech-language pathologist may apply for licensure in advance of a change in his or her primary state of residence.

(5) A license may not be issued by the new home state until the audiologist or speech-language pathologist provides satisfactory evidence of a change in his or her primary state of residence to the new home state and satisfies all applicable requirements to obtain a license from the new home state.

(6) If an audiologist or speech-language pathologist changes his or her primary state of residence by moving from a member state to a nonmember state, the license issued by the prior home state shall convert to a single-state license, valid only in the former home state.

(7) Compact privilege is valid until the expiration date of the home state license. The licensee must comply with the requirements of subsection (1) to maintain compact privilege in the remote state.

(8) A licensee providing audiology or speech-language pathology services in a remote state under compact privilege shall function within the laws and regulations of the remote state.

(9) A remote state may, in accordance with due process and state law, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, or take any other necessary actions to protect the health and safety of its residents.

(10) If a home state license is encumbered, the licensee shall lose compact privilege in all remote states until both of the following occur:

(a) The home state license is no longer encumbered.

(b) Two years have lapsed from the date of the adverse action.

(11) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain compact privilege in any remote state.

(12) Once the requirements of subsection (10) have been met, the licensee must meet the requirements in subsection (1) to obtain compact privilege in a remote state.

ARTICLE V

COMPACT PRIVILEGE TO PRACTICE TELEHEALTH

Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by a home state in accordance with Article III and under rules adopted by the commission, to practice audiology or speech-language pathology in any member state through the use of telehealth under privilege to practice as provided in the compact and rules adopted by the commission.

ARTICLE VI

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

Active duty military personnel, or their spouses, as applicable, shall designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the servicemember is on active duty. Subsequent to designating a home state, the individual shall only change his or her home state only through application for licensure in the new state.

ARTICLE VII

ADVERSE ACTIONS

(1) In addition to the other powers conferred by state law, a remote state may:

(a) Take adverse action against an audiologist's or speech-language pathologist's privilege to practice within that member state.

1. Only the home state has the power to take adverse action against an audiologist's or a speech-language pathologist's license issued by the home state.

2. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

(b) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board in a member state for the attendance and testimony of witnesses or the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence are located.

(c) Complete any pending investigations of an audiologist or speech-language pathologist who changes his or her primary

state of residence during the course of the investigations. The home state also has the authority to take appropriate actions and shall promptly report to the administrator of the data system the conclusions of the investigations. The administrator of the data system shall promptly notify the new home state of any adverse actions.

(d) If otherwise allowed by state law, recover from the affected audiologist or speech-language pathologist the costs of investigations and disposition of cases resulting from any adverse action taken against that audiologist or speech-language pathologist.

(e) Take adverse action based on the factual findings of the remote state, provided that the member state follows the member state's own procedures for taking the adverse action.

(2)(a) In addition to the authority granted to a member state by its respective audiology or speech-language pathology practice act or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(3) If adverse action is taken by the home state against an audiologist's or a speech language pathologist's license, the audiologist's or speech-language pathologist's privilege to

practice in all other member states shall be deactivated until all encumbrances have been removed from the home state license. All home state disciplinary orders that impose adverse action against an audiologist's or a speech language pathologist's license must include a statement that the audiologist's or speech-language pathologist's privilege to practice is deactivated in all member states during the pendency of the order.

(4) If a member state takes adverse action, it must promptly notify the administrator of the data system. The administrator of the data system shall promptly notify the home state of any adverse actions by remote states.

(5) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action.

ARTICLE VIII

ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT COMMISSION

(1) The member states hereby create and establish a joint public agency known as the Audiology and Speech-language Pathology Interstate Compact Commission.

(a) The commission is an instrumentality of the compact states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) This compact does not waive sovereign immunity except to the extent sovereign immunity is waived in the member states.

(2)(a) Each member state must have two delegates selected by that member state's licensing boards. The delegates must be current members of the licensing boards. One delegate must be an audiologist and one delegate must be a speech-language pathologist.

(b) An additional five delegates, who are either public members or board administrators from licensing boards, must be chosen by the executive committee from a pool of nominees provided by the commission at large.

(c) A delegate may be removed or suspended from office as provided by the state law from which the delegate is appointed.

(d) The member state board shall fill any vacancy occurring on the commission within 90 days after the vacancy occurs.

(e) Each delegate is entitled to one vote with regard to the adoption of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs

of the commission.

(f) A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(g) The commission shall meet at least once during each calendar year. Additional meetings must be held as provided in the bylaws and rules.

(3) The commission has the following powers and duties:

(a) Establish the commission's fiscal year.

(b) Establish bylaws.

(c) Establish a code of ethics.

(d) Maintain its financial records in accordance with the bylaws.

(e) Meet and take actions as are consistent with the compact and the bylaws.

(f) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules shall have the force and effect of law and are binding on all member states.

(g) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of an audiology licensing board or a speech-language pathology licensing board to sue or be sued under applicable law is not affected.

(h) Purchase and maintain insurance and bonds.

(i) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(j) Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals appropriate authority to carry out the purposes of the compact, and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(k) Accept any appropriate donations and grants of money, equipment, supplies, and materials and services, and receive, use, and dispose of the same, provided that at all times the commission must avoid any appearance of impropriety or conflict of interest.

(l) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission shall avoid any appearance of impropriety.

(m) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed.

(n) Establish a budget and make expenditures.

(o) Borrow money.

(p) Appoint committees, including standing committees composed of members, and other interested persons as may be

designated in the compact and the bylaws.

(q) Provide and receive information from, and cooperate with, law enforcement agencies.

(r) Establish and elect an executive committee.

(s) Perform other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of audiology and speech-language pathology licensure and practice.

(4) The executive committee shall have the power to act on behalf of the commission according to the terms of the compact.

(a) The executive committee must be composed of 10 members as follows:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. Two ex officio members, consisting of one nonvoting member from a recognized national audiology professional association and one nonvoting member from a recognized national speech-language pathology association.

3. One ex-officio, nonvoting member from the recognized membership organization of the audiology licensing and speech-language pathology licensing boards.

(b) The ex officio members must be selected by their respective organizations.

(c) The commission may remove any member of the executive committee as provided in the bylaws.

(d) The executive committee shall meet at least annually.

(e) The executive committee has the following duties and responsibilities:

1. Recommend to the entire commission changes to the rules or bylaws and changes to this compact legislation, fees paid by member states such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractual or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Other duties as provided by rule or bylaw.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in Article X.

(g) If a meeting or any portion of a meeting is closed under this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(h) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the

reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in minutes. All minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(5) Relating to the financing of the commission, the commission:

(a) Shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) May accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) May levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule binding upon all member states.

(d) May not incur obligations of any kind before securing the funds adequate to meet the same and may not pledge the

credit of any of the member states, except by and with the authority of the member state.

(e) Shall keep accurate accounts of all receipts and disbursements of funds. The receipts and disbursements of funds of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(6) Relating to qualified immunity, defense, and indemnification:

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that this paragraph does not protect any person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(b) The commission shall defend any member, officer,

executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that this paragraph may not be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE IX

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and current significant investigative information on all licensed individuals in member states.

(2) Notwithstanding any other law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, including all of the following information:

(a) Identifying information.

(b) Licensure data.

(c) Adverse actions against a license or compact privilege.

(d) Nonconfidential information related to alternative program participation.

(e) Any denial of application for licensure, and the reason for such denial.

(f) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Current significant investigative information pertaining to a licensee in a member state must be available

only to other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee or an individual applying for a license in any member state must be available to any other member state.

(5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(6) Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE X

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria provided in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, the rule has no further force and

effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule or rules by the commission, and at least 30 days before the meeting at which the rule shall be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(a) On the website of the commission or other publicly accessible platform; and

(b) On the website of each member state audiology licensing board and speech-language pathology licensing board or other publicly accessible platform or the publication where each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of and reason for the proposed rule or amendment.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before the adoption of a proposed rule, the commission

shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(a) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least 25 members.

(b) If a hearing is held on the proposed rule or amendment, the commission must publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the commission must publish the mechanism for access to the electronic hearing.

(c) All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing not less than 5 business days before the scheduled date of the hearing.

(d) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(e) All hearings must be recorded. A copy of the recording must be made available on request.

(7) This article does not require a separate hearing on

each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(8) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(9) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(10) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(11) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article retroactively apply to the rule as soon as reasonably possible, but in no event later than 90 days after the effective date of the rule. For purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or member state funds; or

(c) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

(12) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revisions are subject to challenge by any person for a period of 30 days after posting. A revision may be challenged only on grounds that it results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If no challenge is made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE XI

DISPUTE RESOLUTION

AND ENFORCEMENT

(1)(a) Upon request by a member state, the commission shall attempt to resolve disputes related to the compact that arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(2)(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member must be awarded all costs of litigation, including reasonable attorney fees.

(c) The remedies provided in this subsection are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XII

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(1) The compact becomes effective and binding on the date of legislative enactment of the compact by no fewer than 10 member states. The provisions, which become effective at that time, shall be limited to the powers granted to the commission

relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to implement and administer the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) A member state may withdraw from the compact by enacting a statute repealing the compact.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's audiology licensing board or speech-language pathology licensing board to comply with the investigative and adverse action reporting requirements of the compact before the effective date of withdrawal.

(4) The compact does not invalidate or prevent any audiology or speech-language pathology licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding

upon any member state until it is enacted into the laws of all member states.

ARTICLE XIII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to effectuate its purposes. The provisions of the compact are severable and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected. If the compact is held contrary to the constitution of any member state, the compact shall remain in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

ARTICLE XIV

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) The compact does not prevent the enforcement of any other law of a member state that is not inconsistent with the

compact.

(2) All laws of a member state in conflict with the compact are superseded to the extent of the conflict.

(3) All lawful actions of the commission, including all rules and bylaws adopted by the commission, are binding upon the member states.

(4) All agreements between the commission and the member states are binding in accordance with their terms.

(5) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, the provision is ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 73. The provisions of the Audiology and Speech-Language Pathology Interstate Compact do not authorize the Department of Health or the Board of Speech-Language Pathology and Audiology to collect a compact privilege fee, but rather state that fees of this kind are allowable under the compact. The Department of Health and the Board of Speech-Language Pathology and Audiology must comply with the requirements of s. 456.025.

Section 74. Section 486.028, Florida Statutes, is amended to read:

486.028 License to practice physical therapy required.—A ~~No~~ person may not ~~shall~~ practice, or hold herself or himself out

as being able to practice, physical therapy in this state unless she or he is licensed under ~~in accordance with the provisions of~~ this chapter or holds a compact privilege in this state under the Physical Therapy Licensure Compact as specified in s. 486.112.~~; however, Nothing in~~ This chapter does not ~~shall~~ prohibit any person licensed in this state under any other law from engaging in the practice for which she or he is licensed.

Section 75. Section 486.031, Florida Statutes, is amended to read:

486.031 Physical therapist; licensing requirements; exemption.—

(1) To be eligible for licensing as a physical therapist, an applicant must:

(a)~~(1)~~ Be at least 18 years old;

(b)~~(2)~~ Be of good moral character; and

(c)1.~~(3)(a)~~ Have ~~been~~ graduated from a school of physical therapy which has been approved for the educational preparation of physical therapists by the appropriate accrediting agency recognized by the Council for Higher Education Accreditation or its successor ~~Commission on Recognition of Postsecondary Accreditation~~ or the United States Department of Education at the time of her or his graduation and have passed, to the satisfaction of the board, the American Registry Examination before ~~prior to~~ 1971 or a national examination approved by the board to determine her or his fitness for practice as a physical

therapist under this chapter ~~as hereinafter provided~~;

2.~~(b)~~ Have received a diploma from a program in physical therapy in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapists in this country, as recognized by the appropriate agency as identified by the board, and have passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist under this chapter ~~as hereinafter provided~~; or

3.~~(c)~~ Be entitled to licensure without examination as provided in s. 486.081.

(2) A person licensed as a physical therapist in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 76. Section 486.102, Florida Statutes, is amended to read:

486.102 Physical therapist assistant; licensing requirements; exemption.—

(1) To be eligible for licensing by the board as a physical therapist assistant, an applicant must:

(a)~~(1)~~ Be at least 18 years old;

(b)~~(2)~~ Be of good moral character; and

(c)1.~~(3)(a)~~ Have ~~been~~ graduated from a school providing

~~giving~~ a course of at least ~~not less than~~ 2 years for physical therapist assistants, which has been approved for the educational preparation of physical therapist assistants by the appropriate accrediting agency recognized by the Council for Higher Education Accreditation or its successor ~~Commission on Recognition of Postsecondary Accreditation~~ or the United States Department of Education, at the time of her or his graduation and have passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist assistant under this chapter ~~as hereinafter provided~~;

2.~~(b)~~ Have ~~been~~ graduated from a school providing ~~giving~~ a course for physical therapist assistants in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapist assistants in this country, as recognized by the appropriate agency as identified by the board, and passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist assistant under this chapter ~~as hereinafter provided~~;

3.~~(c)~~ Be entitled to licensure without examination as provided in s. 486.107; or

4.~~(d)~~ Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in this state which was accredited at the time of enrollment; and

a.~~1.~~ Have ~~been~~ graduated or be eligible to graduate from

such school no later than July 1, 2018; and

b.~~2.~~ Have passed to the satisfaction of the board an examination to determine his or her fitness for practice as a physical therapist assistant as provided in s. 486.104.

(2) A person licensed as a physical therapist assistant in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 77. Section 486.107, Florida Statutes, is amended to read:

486.107 Physical therapist assistant; endorsement ~~issuance of license without examination to person licensed in another jurisdiction~~; fee.—

(1) The board may cause a license by endorsement to be issued through the department ~~without examination~~ to any applicant who presents evidence to the board, under oath, of meeting the requirements for licensure by endorsement in s. 456.0145 ~~licensure in another state, the District of Columbia, or a territory, if the standards for registering as a physical therapist assistant or licensing of a physical therapist assistant, as the case may be, in such other state are determined by the board to be as high as those of this state, as established by rules adopted pursuant to this chapter~~. Any person who holds a license pursuant to this section may use the

words "physical therapist assistant," or the letters "P.T.A.," in connection with her or his name to denote licensure hereunder.

(2) At the time of filing an ~~making~~ application for licensing by endorsement under ~~without examination pursuant to the terms of~~ this section, the applicant shall pay to the department a nonrefundable fee not to exceed $175, as determined ~~fixed~~ by the board~~, no part of which will be returned~~.

(3) A person licensed as a physical therapist assistant in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 78. Section 490.006, Florida Statutes, is amended to read:

490.006 Licensure by endorsement.—

(1) The department shall license a person as a psychologist or school psychologist who, upon applying to the department and remitting the appropriate fee, demonstrates to the department or, in the case of psychologists, to the board that the applicant meets the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Is a diplomate in good standing with the American Board of Professional Psychology, Inc.; or~~

~~(b) Possesses a doctoral degree in psychology and has at~~

~~least 10 years of experience as a licensed psychologist in any jurisdiction or territory of the United States within the 25 years preceding the date of application.~~

~~(2) In addition to meeting the requirements for licensure set forth in subsection (1), an applicant must pass that portion of the psychology or school psychology licensure examinations pertaining to the laws and rules related to the practice of psychology or school psychology in this state before the department may issue a license to the applicant.~~

~~(3) The department shall not issue a license by endorsement to any applicant who is under investigation in this or another jurisdiction for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 490.009 shall apply.~~

(2)~~(4)~~ A person licensed as a psychologist in another state who is practicing pursuant to the Psychology Interjurisdictional Compact under s. 490.0075, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 79. Section 486.112, Florida Statutes, is created to read:

486.112 Physical Therapy Licensure Compact.—The Physical Therapy Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining

therein in the form substantially as follows:

ARTICLE I

PURPOSE AND OBJECTIVES

(1) The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The compact preserves the regulatory authority of member states to protect public health and safety through their current systems of state licensure. For purposes of state regulation under the compact, the practice of physical therapy is deemed to have occurred in the state where the patient is located at the time physical therapy is provided to the patient.

(2) The compact is designed to achieve all of the following objectives:

(a) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' ability to protect the public's health and safety.

(c) Encourage the cooperation of member states in regulating multistate physical therapy practice.

(d) Support spouses of relocating military members.

(e) Enhance the exchange of licensure, investigative, and

disciplinary information between member states.

(f) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

ARTICLE II

DEFINITIONS

As used in the compact, and except as otherwise provided, the term:

(1) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapter 1209 or chapter 1211.

(2) "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a state's physical therapy licensing board. The term includes, but is not limited to, programs that address substance abuse issues.

(4) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or physical therapist assistant in the remote state under its laws and rules.

(5) "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, and completion of, educational and professional activities relevant to the practice of physical therapy.

(6) "Data system" means the coordinated database and reporting system created by the Physical Therapy Compact Commission for the exchange of information between member states relating to licensees or applicants under the compact, including identifying information, licensure data, investigative information, adverse actions, nonconfidential information related to alternative program participation, any denials of applications for licensure, and other information as specified by commission rule.

(7) "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

(8) "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(9) "Home state" means the member state that is the licensee's primary state of residence.

(10) "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) "Jurisprudence requirement" means the assessment of

an individual's knowledge of the laws and rules governing the practice of physical therapy in a specific state.

(12) "Licensee" means an individual who currently holds an authorization from a state to practice as a physical therapist or physical therapist assistant.

(13) "Member state" means a state that has enacted the compact.

(14) "Physical therapist" means an individual licensed by a state to practice physical therapy.

(15) "Physical therapist assistant" means an individual licensed by a state to assist a physical therapist in specified areas of physical therapy.

(16) "Physical therapy" or "the practice of physical therapy" means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(17) "Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(18) "Physical therapy licensing board" means the agency of a state which is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(19) "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise the compact privilege.

(20) "Rule" means a regulation, principle, or directive

adopted by the commission which has the force of law.

(21) "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of physical therapy.

ARTICLE III

STATE PARTICIPATION IN THE COMPACT

(1) To participate in the compact, a state must do all of the following:

(a) Participate fully in the commission's data system, including using the commission's unique identifier, as defined by commission rule.

(b) Have a mechanism in place for receiving and investigating complaints about licensees.

(c) Notify the commission, in accordance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(d) Fully implement a criminal background check requirement, within a timeframe established by commission rule, which uses results from the Federal Bureau of Investigation record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission's rules.

(f) Use a recognized national examination as a requirement

for licensure pursuant to the commission's rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

(4) Member states may charge a fee for granting a compact privilege.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or

compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the compact privilege within a remote state.

(f) Pay any applicable fees, including any state fee, for the compact privilege.

(g) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(h) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege

in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.

ARTICLE V

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

(1) Home of record.

(2) Permanent change of station location.

(3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI

ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse action against a license issued by the home state.

(2) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(3) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without

prior authorization from such other member state.

(4) A member state may investigate actual or alleged violations of the laws and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant practicing under the compact who holds a license or compact privilege in such other member state.

(5) A remote state may do any of the following:

(a) Take adverse actions as set forth in subsection (4) of article IV against a licensee's compact privilege in the state.

(b) Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a member state for the attendance and testimony of witnesses or for the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service laws of the state where the witnesses or evidence is located.

(c) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(6)(a) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

ARTICLE VII

ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

(1) COMMISSION CREATED.—The member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(a) The commission is an instrumentality of the member states.

(b) Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact may not be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) Each member state has and is limited to one delegate selected by that member state's physical therapy licensing board to serve on the commission. The delegate must be a current member of the physical therapy licensing board who is a physical therapist, a physical therapist assistant, a public member, or the board administrator.

(b) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring on the commission must be filled by the physical therapy licensing board of the member state for which the vacancy exists.

(c) Each delegate is entitled to one vote with regard to the adoption of rules and bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(d) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(e) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in article IX.

(g) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, or discipline of, or other matters, practices, or procedures related to, specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation against the commission, executive board, or other committees of the commission.

4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. An accusation of any person of a crime or a formal censure of any person.

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential.

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Investigatory records compiled for law enforcement purposes.

9. Information related to any investigative reports prepared by or on behalf of or for use of the commission or

other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state statute.

(h) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are be binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix compensation of, define duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission

avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall consist of the following nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. One ex-officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be

audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any

member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to

the data system on all individuals to whom the compact is applicable as required by the rules of the commission, including all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Investigative information.

(d) Adverse actions against a license or compact privilege.

(e) Nonconfidential information related to alternative program participation.

(f) Any denial of application for licensure and the reason for such denial.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Investigative information in the system pertaining to a licensee in any member state must be available only to other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license in a member state. Adverse action information pertaining to a licensee in any member state must be available to all other member states.

(5) Member states contributing information to the data system may designate information that may not be shared with the

public without the express permission of the contributing state.

(6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE IX

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule or rules by the commission, and at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.

(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed

rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This section may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public

hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this section are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of

the commission. The revision is subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE X

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to carry out the compact's purposes and intent. The provisions of the compact and the rules adopted pursuant thereto shall have standing as statutory law.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission is entitled to receive service of

process in any such proceeding and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or the adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or the adopted rules, the commission must do all of the following:

1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and any other action to be taken by the commission.

2. Provide remedial training and specific technical assistance regarding the default.

(b) If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by the compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(c) Termination of membership in the compact may be imposed only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to

suspend or terminate a defaulting member state to the governor and majority and minority leaders of the defaulting state's legislature and to each of the member states.

(d) A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission does not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission must attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact and the commission's rules.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies under this article are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XI

DATE OF IMPLEMENTATION OF THE PHYSICAL THERAPY COMPACT AND ASSOCIATED RULES; WITHDRAWAL; AND AMENDMENTS

(1) The compact becomes effective on the date that the compact statute is enacted into law in the tenth member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and

exercise rulemaking powers necessary for the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date that the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the same.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the provisions of the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all

member states.

ARTICLE XII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to carry out the purposes thereof. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any member state, the compact remains in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

Section 80. The provisions of the Physical Therapy Licensure Compact do not authorize the Department of Health or the Board of Physical Therapy to collect a compact privilege fee, but rather state that fees of this kind are allowable under the compact. The Department of Health and the Board of Physical Therapy must comply with the requirements of s. 456.025.

Section 81. Subsection (5) is added to section 486.023, Florida Statutes, to read:

486.023 Board of Physical Therapy Practice.—

(5) The board shall appoint a person to serve as the state's delegate on the Physical Therapy Compact Commission, as required under s. 486.112.

Section 82. Section 486.125, Florida Statutes, is amended to read:

486.125 Refusal, revocation, or suspension of license; administrative fines 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) or s. 486.112:

(a) Being unable to practice physical 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 any mental or physical condition.

1. In enforcing this paragraph, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice physical therapy due to the reasons stated in this paragraph, the department shall have the authority to compel a physical therapist or physical therapist assistant to submit to a mental or physical examination by a physician designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement

in the circuit court where the licensee resides or serves as a physical therapy practitioner. The licensee against whom the petition is filed may ~~shall~~ not be named or identified by initials in any public court records or documents, and the proceedings must ~~shall~~ be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011.

2. A physical therapist or physical therapist assistant whose license is suspended or revoked pursuant to this subsection shall, at reasonable intervals, be given an opportunity to demonstrate that she or he can resume the competent practice of physical therapy with reasonable skill and safety to patients.

3. Neither the record of proceeding nor the orders entered by the board in any proceeding under this subsection may be used against a physical therapist or physical therapist assistant in any other proceeding.

(b) Having committed fraud in the practice of physical therapy or deceit in obtaining a license as a physical therapist or as a physical therapist assistant.

(c) Being convicted or found guilty regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of physical therapy or to the ability to practice physical therapy. The entry of any plea of nolo contendere is ~~shall be~~ considered a conviction for purpose of

this chapter.

(d) Having treated or undertaken to treat human ailments by means other than by physical therapy, as defined in this chapter.

(e) Failing to maintain acceptable standards of physical therapy practice as set forth by the board in rules adopted pursuant to this chapter.

(f) Engaging directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services, or having been found to profit by means of a credit or other valuable consideration, such as an unearned commission, discount, or gratuity, with any person referring a patient or with any relative or business associate of the referring person. ~~Nothing in~~ This chapter may not ~~shall~~ be construed to prohibit the members of any regularly and properly organized business entity which is comprised of physical therapists and which is recognized under the laws of this state from making any division of their total fees among themselves as they determine necessary.

(g) Having a license revoked or suspended; having had other disciplinary action taken against her or him; or having had her or his application for a license refused, revoked, or suspended by the licensing authority of another state, territory, or country.

(h) Violating a lawful order of the board or department

previously entered in a disciplinary hearing.

(i) Making or filing a report or record which the licensee knows to be false. Such reports or records shall include only those which are signed in the capacity of a physical therapist.

(j) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know that she or he is not competent to perform, including, but not limited to, specific spinal manipulation.

(k) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) ~~of this section~~ or who is found guilty of violating any provision of s. 456.072(1).

(b) The board may take adverse action against a physical therapist's or a physical therapist assistant's compact privilege under the Physical Therapy Licensure Compact pursuant to s. 486.112, and may impose any of the penalties in s. 456.072(2), if a physical therapist or physical therapist assistant commits an act specified in subsection (1) or s. 456.072(1).

(3) The board may ~~shall~~ not reinstate the license of a physical therapist or physical therapist assistant or approve

~~cause~~ a license to be issued to a person it has deemed unqualified until such time as it is satisfied that she or he has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of physical therapy.

Section 83. Paragraph (b) of subsection (1) of section 624.27, Florida Statutes, is amended to read:

624.27 Direct health care agreements; exemption from code.—

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

(b) "Health care provider" means a health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, ~~or~~ chapter 466, chapter 490, or chapter 491, or a health care group practice, who provides health care services to patients.

Section 84. Subsections (4) through (12) of section 95.11, Florida Statutes, are renumbered as subsections (5) through (13), respectively, paragraph (b) of subsection (2), paragraph (n) of subsection (3), paragraphs (f) and (g) of present subsection (5), and present subsection (10) are amended, and a new subsection (4) is added to that section, to read:

95.11 Limitations other than for the recovery of real property.—Actions other than for recovery of real property shall be commenced as follows:

(2) WITHIN FIVE YEARS.—

(b) A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (6)(e) ~~paragraph (5)(e)~~, s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (6)(h) ~~paragraph (5)(h)~~.

(3) WITHIN FOUR YEARS.—

(n) An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (5), (6), and (8) ~~subsections (4), (5), and (7)~~.

(4) WITHIN THREE YEARS.—An action to collect medical debt for services rendered by a facility licensed under chapter 395, provided that the period of limitations shall run from the date on which the facility refers the medical debt to a third party for collection.

(6)~~(5)~~ WITHIN ONE YEAR.—

(f) Except for actions described in subsection (9)~~(8)~~, a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.

(g) Except for actions described in subsection (9)~~(8)~~, an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's

confinement.

(11) ~~(10)~~ FOR INTENTIONAL TORTS RESULTING IN DEATH FROM ACTS DESCRIBED IN S. 782.04 OR S. 782.07.—Notwithstanding paragraph (5)(e) ~~paragraph (4)(e)~~, an action for wrongful death seeking damages authorized under s. 768.21 brought against a natural person for an intentional tort resulting in death from acts described in s. 782.04 or s. 782.07 may be commenced at any time. This subsection shall not be construed to require an arrest, the filing of formal criminal charges, or a conviction for a violation of s. 782.04 or s. 782.07 as a condition for filing a civil action.

Section 85. Section 222.26, Florida Statutes, is created to read:

222.26 Additional exemptions from legal process concerning medical debt.—If a debt is owed for medical services provided by a facility licensed under chapter 395, the following property is exempt from attachment, garnishment, or other legal process in an action on such debt:

(1) A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle as defined in s. 320.01(1).

(2) A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption under s. 4, Art. X of the State Constitution.

Section 86. Section 627.446, Florida Statutes, is created

to read:

627.446 Advanced explanation of benefits.—

(1) As used in this section, the term "health insurer" means a health insurer issuing individual or group coverage or a health maintenance organization issuing coverage through an individual or a group contract.

(2) Each health insurer shall prepare an advanced explanation of benefits upon receiving a patient estimate from a facility pursuant to s. 395.301(1). The health insurer must provide the advanced explanation of benefits to the insured no later than 1 business day after receiving the patient estimate from the facility or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after receiving such estimate.

(3) At a minimum, the advanced explanation of benefits must include detailed coverage and cost-sharing information pursuant to the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260.

Section 87. Section 627.447, Florida Statutes, is created to read:

627.447 Disclosure of discounted cash prices.—A health insurer may not prohibit a provider from disclosing to an insured the option to pay the provider's discounted cash price for health care services. For purposes of this section, the term "discounted cash price" means:

(1) With respect to a hospital facility, the same meaning as in 45 CFR 180.20. The term does not include the amount charged to an individual pursuant to a facility's financial assistance policy.

(2) With respect to a provider that is not a hospital, the charge that is applied to an individual who paid for a health care service without filing an insurance claim.

Section 88. Paragraphs (b) and (c) of subsection (2), subsection (3), and paragraph (a) of subsection (4) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

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

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 627.446 ~~s. 624.603~~.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health insurer provides ~~may provide~~ to an insured for choosing certain shoppable health care services under a shared savings incentive program which ~~and~~ may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(3) A health insurer must ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health

insurer ~~that offers a shared savings incentive program~~ must:

(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program, ~~and~~ the procedure to participate in the program, and that participation by the insured is voluntary and optional.

(d) Publish on a web page easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical

expense for such purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

Section 89. Paragraph (a) of subsection (4) of section 627.6648, Florida Statutes, is amended to read:

627.6648 Shared savings incentive program.—

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical expense for such purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

Section 90. Paragraph (a) of subsection (4) of section 641.31076, Florida Statutes, is amended to read:

641.31076 Shared savings incentive program.—

(4) A shared savings incentive offered by a health maintenance organization in accordance with this section:

(a) Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical expense for such purposes.

Section 91. 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 300 ~~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 92. Subsection (14) of section 768.28, Florida Statutes, is amended, and paragraphs (j), (k), and (l) are added to subsection (10) of that section, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(j) For purposes of this section, the representatives appointed from the Board of Medicine and the Board of Osteopathic Medicine, when serving as commissioners of the

Interstate Medical Licensure Compact Commission pursuant to s. 456.4501, and any administrator, officer, executive director, employee, or representative of the Interstate Medical Licensure Compact Commission, when acting within the scope of their employment, duties, or responsibilities in this state, are considered agents of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

(k) For purposes of this section, the individuals appointed under s. 468.1135(4) as the state's delegates on the Audiology and Speech-Language Pathology Interstate Compact Commission, when serving in that capacity under s. 468.1335, and any administrator, officer, executive director, employee, or representative of the commission, when acting within the scope of his or her employment, duties, or responsibilities in the state, is considered an agent of the state. The commission shall pay any claims or judgments under this section and may maintain insurance coverage to pay any such claims or judgments.

(l) For purposes of this section, the individual appointed under s. 486.023(5) as the state's delegate on the Physical Therapy Compact Commission, when serving in that capacity under s. 486.112, and any administrator, officer, executive director, employee, or representative of the Physical Therapy Compact Commission, when acting within the scope of his or her employment, duties, or responsibilities in this state, is

considered an agent of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

(14) Every claim against the state or one of its agencies or subdivisions for damages for a negligent or wrongful act or omission pursuant to this section shall be forever barred unless the civil action is commenced by filing a complaint in the court of appropriate jurisdiction within 4 years after such claim accrues; except that an action for contribution must be commenced within the limitations provided in s. 768.31(4), and an action for damages arising from medical malpractice or wrongful death must be commenced within the limitations for such actions in s. 95.11(5) ~~s. 95.11(4)~~.

Section 93. Paragraph (f) is added to subsection (3) of section 1002.32, Florida Statutes, to read:

1002.32 Developmental research (laboratory) schools.—

(3) MISSION.—The mission of a lab school shall be the provision of a vehicle for the conduct of research, demonstration, and evaluation regarding management, teaching, and learning. Programs to achieve the mission of a lab school shall embody the goals and standards established pursuant to ss. 1000.03(5) and 1001.23(1) and shall ensure an appropriate education for its students.

(f) Each lab school shall develop programs that accelerate the entry of students into articulated health care programs at

its affiliated university or at any public or private postsecondary institution, with the approval of the university president. Each lab school shall offer technical assistance to any school district seeking to replicate the lab school's programs and must annually report to the President of the Senate and the Speaker of the House of Representatives on the development and results of such programs, when available.

Section 94. Paragraph (c) is added to subsection (6) of section 1004.015, Florida Statutes, to read:

1004.015 Florida Talent Development Council.—

(6) The council shall coordinate, facilitate, and communicate statewide efforts to meet supply and demand needs for the state's health care workforce. Annually, by December 1, the council shall report on the implementation of this subsection and any other relevant information on the Florida Talent Development Council's web page located on the Department of Economic Opportunity's website. To support the efforts of the council, the Board of Governors and the State Board of Education shall:

(c) Require the Commission for Independent Education and the Independent Colleges and Universities of Florida to annually report, for each medical school graduate, by institution and program, the graduates' accepted postgraduation residency programs, including location and specialty. For graduates who accepted a residency program in this state, reported data shall

identify the accredited program and sponsoring institution of the residency program.

Section 95. Paragraph (b) of subsection (3) and paragraph (b) of subsection (9) of section 1009.8962, Florida Statutes, are amended to read:

1009.8962 Linking Industry to Nursing Education (LINE) Fund.—

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

(b) "Institution" means a school district career center under s. 1001.44;~~,~~ a charter technical career center under s. 1002.34;~~,~~ a Florida College System institution;~~,~~ a state university;~~, or~~ an independent nonprofit college or university located and chartered in this state and accredited by an agency or association that is recognized by the database created and maintained by the United States Department of Education to grant baccalaureate degrees; or an independent school, college, or university with an accredited nursing education program as defined in s. 464.003 which is located in and chartered by the state and is licensed by the Commission for Independent Education pursuant to s. 1005.31, which has a nursing education program that meets or exceeds the following:

1. For a certified nursing assistant program, a completion rate of at least 70 percent for the prior year.

2. For a licensed practical nurse, associate of science in nursing, and bachelor of science in nursing program, a first-

time passage rate on the National Council of State Boards of Nursing Licensing Examination of at least 75 ~~70~~ percent for the prior year based on at least 10 testing participants.

(9)

(b) Annually, by February 1, ~~each institution awarded grant funds in the previous fiscal year shall submit a report to~~ the Board of Governors and the ~~or~~ Department of Education shall submit to the Governor, President of the Senate, and Speaker of the House of Representatives a report~~, as applicable,~~ that demonstrates the expansion as outlined in each ~~the~~ proposal and the use of funds. At minimum, the report must include, by program level, the number of additional nursing education students enrolled; if scholarships were awarded using grant funds, the number of students who received scholarships and the average award amount; and the outcomes of students as reported by the Florida Talent Development Council pursuant to s. 1004.015(6).

Section 96. Section 486.025, Florida Statutes, is amended to read:

486.025 Powers and duties of the Board of Physical Therapy Practice.—The board may administer oaths, summon witnesses, take testimony in all matters relating to its duties under this chapter, establish or modify minimum standards of practice of physical therapy as defined in s. 486.021, including, but not limited to, standards of practice for the performance of dry

needling by physical therapists, and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this chapter. The board may also review the standing and reputability of any school or college offering courses in physical therapy and whether the courses of such school or college in physical therapy meet the standards established by the appropriate accrediting agency referred to in s. 486.031(1)(c) ~~s. 486.031(3)(a)~~. In determining the standing and reputability of any such school and whether the school and courses meet such standards, the board may investigate and personally inspect the school and courses.

Section 97. Paragraph (b) of subsection (1) of section 486.0715, Florida Statutes, is amended to read:

486.0715 Physical therapist; issuance of temporary permit.—

(1) The board shall issue a temporary physical therapist permit to an applicant who meets the following requirements:

(b) Is a graduate of an approved United States physical therapy educational program and meets all the eligibility requirements for licensure under ch. 456, s. 486.031(1)(a), (b), and (c)1. ~~s. 486.031(1)-(3)(a)~~, and related rules, except passage of a national examination approved by the board is not required.

Section 98. Paragraph (b) of subsection (1) of section 486.1065, Florida Statutes, is amended to read:

486.1065 Physical therapist assistant; issuance of

temporary permit.—

(1) The board shall issue a temporary physical therapist assistant permit to an applicant who meets the following requirements:

(b) Is a graduate of an approved United States physical therapy assistant educational program and meets all the eligibility requirements for licensure under ch. 456, s. 486.102(1)(a), (b), and (c)1. ~~s. 486.102(1)-(3)(a)~~, and related rules, except passage of a national examination approved by the board is not required.

Section 99. Subsection (3) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(3) USE OF FUNDS.—It is the intent of the Legislature that funds as appropriated shall be utilized by the department for the purpose of increasing the number of primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses in rural areas, either through the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program established in s. 381.402 ~~as defined by s. 1009.65~~ or through a federal loan repayment program which requires state matching funds. The department may use funds appropriated for the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program as matching funds for federal loan

repayment programs for health care personnel, such as that authorized in Pub. L. No. 100-177, s. 203. If the department receives federal matching funds, the department shall only implement the federal program. Reimbursement through either program shall be limited to:

(a) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(b) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural area health education centers, as defined in this section. These personnel shall practice:

1. In a county with a population density of no greater than 100 persons per square mile; or

2. Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

If the department administers a federal loan repayment program, priority shall be given to obligating state and federal matching funds pursuant to paragraphs (a) and (b). The department may use federal matching funds in other health workforce shortage areas and medically underserved areas in the state for loan repayment

programs for primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses who are employed by publicly financed health care programs that serve medically indigent persons.

Section 100. Subsection (1) of section 458.316, Florida Statutes, is amended to read:

458.316 Public health certificate.—

(1) Any person desiring to obtain a public health certificate shall submit an application fee not to exceed $300 and shall demonstrate to the board that he or she is a graduate of an accredited medical school and holds a master of public health degree or is board eligible or certified in public health or preventive medicine, or is licensed to practice medicine without restriction in another jurisdiction in the United States and holds a master of public health degree or is board eligible or certified in public health or preventive medicine, and shall meet the requirements in s. 458.311(1)(a)-(g) and (6) ~~(5)~~.

Section 101. Section 458.3165, Florida Statutes, is amended to read:

458.3165 Public psychiatry certificate.—The board shall issue a public psychiatry certificate to an individual who remits an application fee not to exceed $300, as set by the board, who is a board-certified psychiatrist, who is licensed to practice medicine without restriction in another state, and who meets the requirements in s. 458.311(1)(a)-(g) and (6) ~~(5)~~. A

recipient of a public psychiatry certificate may use the certificate to work at any public mental health facility or program funded in part or entirely by state funds.

(1) Such certificate shall:

(a) Authorize the holder to practice only in a public mental health facility or program funded in part or entirely by state funds.

(b) Be issued and renewable biennially if the State Surgeon General and the chair of the department of psychiatry at one of the public medical schools or the chair of the department of psychiatry at the accredited medical school at the University of Miami recommend in writing that the certificate be issued or renewed.

(c) Automatically expire if the holder's relationship with a public mental health facility or program expires.

(d) Not be issued to a person who has been adjudged unqualified or guilty of any of the prohibited acts in this chapter.

(2) The board may take disciplinary action against a certificateholder for noncompliance with any part of this section or for any reason for which a regular licensee may be subject to discipline.

Section 102. Subsection (3) of section 468.209, Florida Statutes, is amended to read:

468.209 Requirements for licensure.—

(3) If the board determines that an applicant is qualified to be licensed by endorsement under s. 456.0145 ~~s. 468.213~~, the board may issue the applicant a temporary permit to practice occupational therapy until the next board meeting at which license applications are to be considered, but not for a longer period of time. Only one temporary permit by endorsement shall be issued to an applicant, and it shall not be renewable.

Section 103. Subsection (5) of section 468.511, Florida Statutes, is amended to read:

468.511 Dietitian/nutritionist; temporary permit.—

~~(5) If the board determines that an applicant is qualified to be licensed by endorsement under s. 468.513, the board may issue the applicant a temporary permit to practice dietetics and nutrition until the next board meeting at which license applications are to be considered, but not for a longer period of time.~~

Section 104. Paragraphs (a) and (j) of subsection (1) of section 475.01, Florida Statutes, are amended to read:

475.01 Definitions.—

(1) As used in this part:

(a) "Broker" means a person who, for another, and for a compensation or valuable consideration directly or indirectly paid or promised, expressly or impliedly, or with an intent to collect or receive a compensation or valuable consideration therefor, appraises, auctions, sells, exchanges, buys, rents, or

offers, attempts or agrees to appraise, auction, or negotiate the sale, exchange, purchase, or rental of business enterprises or business opportunities or any real property or any interest in or concerning the same, including mineral rights or leases, or who advertises or holds out to the public by any oral or printed solicitation or representation that she or he is engaged in the business of appraising, auctioning, buying, selling, exchanging, leasing, or renting business enterprises or business opportunities or real property of others or interests therein, including mineral rights, or who takes any part in the procuring of sellers, purchasers, lessors, or lessees of business enterprises or business opportunities or the real property of another, or leases, or interest therein, including mineral rights, or who directs or assists in the procuring of prospects or in the negotiation or closing of any transaction which does, or is calculated to, result in a sale, exchange, or leasing thereof, and who receives, expects, or is promised any compensation or valuable consideration, directly or indirectly therefor; and all persons who advertise rental property information or lists. A broker renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~. Where the term "appraise" or "appraising" appears in the definition of the term "broker," it specifically excludes those appraisal services which must be performed only by a state-licensed or state-certified appraiser, and those appraisal

services which may be performed by a registered trainee appraiser as defined in part II. The term "broker" also includes any person who is a general partner, officer, or director of a partnership or corporation which acts as a broker. The term "broker" also includes any person or entity who undertakes to list or sell one or more timeshare periods per year in one or more timeshare plans on behalf of any number of persons, except as provided in ss. 475.011 and 721.20.

(j) "Sales associate" means a person who performs any act specified in the definition of "broker," but who performs such act under the direction, control, or management of another person. A sales associate renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~.

Section 105. Paragraph (h) of subsection (1) of section 475.611, Florida Statutes, is amended to read:

475.611 Definitions.—

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

(h) "Appraiser" means any person who is a registered trainee real estate appraiser, a licensed real estate appraiser, or a certified real estate appraiser. An appraiser renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~.

Section 106. Subsection (7) of section 517.191, Florida Statutes, is amended to read:

517.191 Injunction to restrain violations; civil penalties; enforcement by Attorney General.—

(7) Notwithstanding s. 95.11(5)(f) ~~s. 95.11(4)(f)~~, an enforcement action brought under this section based on a violation of any provision of this chapter or any rule or order issued under this chapter shall be brought within 6 years after the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 8 years after the date such violation occurred.

Section 107. Subsection (4) of section 787.061, Florida Statutes, is amended to read:

787.061 Civil actions by victims of human trafficking.—

(4) STATUTE OF LIMITATIONS.—The statute of limitations as specified in s. 95.11(8) or (10) ~~s. 95.11(7) or (9)~~, as applicable, governs an action brought under this section.

Section 108. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $30 million in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids - Health Care Education Reimbursement and Loan Repayment Program category to the Department of Health for the Florida Reimbursement Assistance for Medical Education Program established in s. 381.402, Florida Statutes.

Section 109. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $8 million in recurring funds from the

General Revenue Fund is appropriated in the Dental Student Loan Repayment Program category to the Department of Health for the Dental Student Loan Repayment Program established in s. 381.4019, Florida Statutes.

Section 110. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $23,357,876 in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids - Minority Health Initiatives category to the Department of Health to expand statewide the telehealth minority maternity care program established in s. 383.2163, Florida Statutes. The department shall establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The department shall identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the region, the neonatal intensive care unit levels of hospitals within the region, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.

Section 111. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $25 million in recurring funds from the General Revenue Fund is appropriated to the Agency for Health Care Administration to implement the Training, Education, and

Clinicals in Health (TEACH) Funding Program established in s. 409.91256, Florida Statutes, as created by this act.

Section 112. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs required by s. 1002.32, Florida Statutes. Each of these state universities shall receive $500,000 from this appropriation.

Section 113. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $5 million in recurring funds from the General Revenue Fund is appropriated in the Aid to Local Governments Grants and Aids - Nursing Education category to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund established in s. 1009.8962, Florida Statutes.

Section 114. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $21,315,000 in recurring funds from the General Revenue Fund and $28,685,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration for the Slots for Doctors Program established in s. 409.909, Florida Statutes.

Section 115. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $42,630,000 in recurring funds from the Grants and Donations Trust Fund and $57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration to provide to statutory teaching hospitals as defined in s. 408.07(46), Florida Statutes, which provide highly specialized tertiary care, including comprehensive stroke and Level 2 adult cardiovascular services; NICU II and III; and adult open heart; and which have more than 30 full-time equivalent (FTE) residents over the Medicare cap in accordance with the CMS-2552 provider 2021 fiscal year-end federal Centers for Medicare and Medicaid Services Healthcare Cost Report, HCRIS data extract on December 1, 2022, worksheet E-4, line 6 minus worksheet E-4, line 5, shall be designated as a High Tertiary Statutory Teaching Hospital and be eligible for funding calculated on a per Graduate Medical Education resident-FTE proportional allocation that shall be in addition to any other Graduate Medical Education funding. Of these funds, $44,562,400 shall be first distributed to hospitals with greater than 500 unweighted fiscal year 2022-2023 FTEs. The remaining funds shall be distributed proportionally based on the total unweighted fiscal year 2022-2023 FTEs. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations

Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section.

Section 116. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $57,402,343 in recurring funds from the General Revenue Fund and $77,250,115 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology. The fiscal year 2024-2025 General Appropriations Act shall establish the DRG reimbursement methodology for hospital inpatient services as directed in s. 409.905(5)(c), Florida Statutes.

Section 117. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $14,888,903 in recurring funds from the General Revenue Fund and $20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for dental care services. The funding shall be held in reserve. The agency shall develop a plan to increase Medicaid reimbursement rates for preventive dental care services by September 1, 2024. The agency may submit a budget amendment pursuant to chapter 216, Florida Statutes, requesting release of the funding. The budget amendment must include the final plan to increase Medicaid reimbursement rates for preventive dental care

services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 118. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $83,456,275 in recurring funds from the General Revenue Fund and $112,312,609 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community-Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase.

Section 119. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $11,525,152 in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids - Community Mental Health Services category to the Department of Children and Families to enhance crisis diversion through mobile response teams established under s. 394.495, Florida Statutes, by expanding existing or establishing new mobile response teams to increase access, reduce response times, and ensure coverage in every county.

Section 120. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $10 million in recurring funds from the General Revenue Fund is appropriated to the Department of Health to implement the Health Care Screening and Services Grant Program established in s. 381.9855, Florida Statutes, as created by this act.

Section 121. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $150,000 in nonrecurring funds from the General Revenue Fund and $150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers. The agency shall submit the reimbursement methodology and estimated fiscal impact to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Appropriations Committee, and the chair of the House Appropriations Committee no later than December 31, 2024.

Section 122. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $12,365,771 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,514,132 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 123. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $14,580,660 in recurring funds from the General Revenue Fund and $19,622,154 in recurring funds from the

Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 124. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $5,522,795 in recurring funds from the General Revenue Fund and $7,432,390 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 125. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $585,758 in recurring funds and $1,673,421 in nonrecurring funds from the General Revenue Fund, $928,001 in recurring funds and $54,513 in nonrecurring funds from the Health Care Trust Fund, $100,000 in nonrecurring funds from the Administrative Trust Fund, and $585,758 in recurring funds and $1,573,421 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration, and 20 full-time equivalent positions with the

associated salary rate of 1,247,140 are authorized for the purpose of implementing this act.

Section 126. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $2,389,146 in recurring funds and $1,190,611 in nonrecurring funds from the General Revenue Fund and $1,041,578 in recurring funds and $287,633 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health, and 25 full-time equivalent positions with the associated salary rate of 1,739,740, are authorized for the purpose of implementing this act.

Section 127. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

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 & Human Services Committee

Representative Grant offered the following:

Amendment (with title amendment)

Remove lines 2629-2730 and lines 3669-3687 and lines 3800-3884 and lines 4503-4579 and lines 4776-5000 and lines 6185-6245 and lines 7598-7616

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

Remove lines 273-300 and insert:

criteria; amending s. 456.073, F.S.; requiring the

Remove lines 394-396 and insert:

compact; amending s. 458.311, F.S.;

Remove lines 406-408 and insert:
amending s. 458.314, F.S.; authorizing
Remove lines 443-447 and insert:
Medicine, respectively, to adopt rules; creating s. 464.0121, F.S.; providing that
Remove lines 474-483 and insert:
Nursing; creating s. 458.3129 and 459.074, F.S.; providing that
Remove lines 593-594 and insert:
ss. 486.028, 486.031, and 486.102, F.S.; exempting from licensure requirements
Remove line 746 and insert:
475.01, 475.611, 517.191, and

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7021 PCB CFS 24-01 Mental Health and Substance Abuse
SPONSOR(S): Health Care Appropriations Subcommittee, Children, Families & Seniors Subcommittee, Maney and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1784

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	18 Y, 0 N	Curry	Brazzell
1) Health Care Appropriations Subcommittee	14 Y, 0 N, As CS	Fontaine	Clark
2) Health & Human Services Committee		Curry	Calamas

SUMMARY ANALYSIS

In Florida, the Baker Act provides a legal procedure for voluntary and involuntary mental health examination and treatment. The Marchman Act addresses substance abuse through a comprehensive system of prevention, detoxification, and treatment services. The Department of Children and Families (DCF) is the single state authority for substance abuse and mental health treatment services in Florida.

The bill modifies the Baker Act and makes significant changes to the Marchman Act, the statutory processes for mental health and substance abuse examinations and treatment, respectively.

The bill amends the Baker Act in that it:

- Combines processes for courts to order individuals to involuntary outpatient services and involuntary inpatient placement in the Baker Act, to streamline the process for obtaining involuntary services, and providing more flexibility for courts to meet individuals' treatment needs.
- Grants law enforcement officers discretion on initiating involuntary examinations.

The bill amends the Marchman Act in that it:

- Repeals existing provisions for court-ordered involuntary assessments and stabilization in the Marchman Act, and creates a new consolidated involuntary treatment process.
- Prohibits courts from ordering an individual with a developmental disability who lacks a co-occurring mental illness to a state mental health treatment facility for involuntary inpatient placement.
- Revises the voluntariness provision under the Baker Act to allow a minor's voluntary admission after a clinical review, rather than a hearing, has been conducted.
- Authorizes a witness to appear remotely upon a showing of good cause and with consent by all parties.
- Allows an individual to be admitted as a civil patient in a state mental health treatment facility without a transfer evaluation and prohibits a court, in a hearing for placement in a treatment facility, from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill amends both acts in that it:

- Creates a more comprehensive and personalized discharge planning process.
- Requires DCF to publish certain specified reports on its website.
- Removes limitations on advance practice registered nurses and physician assistants serving the physical health needs of individuals receiving psychiatric care.
- Allows a psychiatric nurse to release a patient from a receiving facility if certain criteria are met.
- Removes the 30-bed cap for crisis stabilization units.
- Appropriates the sum of $50,000,000 of recurring funds from the General Revenue Fund for the 2024-25 fiscal year to the Department of Children and Families to implement the bill.

The bill appropriates $50,000,000 to the Department of Children and Families to implement certain provisions of the bill.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. Nearly one in five adults lives with a mental illness.[4] During their childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is much lower, at about 22%.[5]

Mental Health Safety Net Services

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Current Situation - Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.[6] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[7] MEs were fully implemented statewide in 2013, serving all geographic regions.

[1] World Health Organization, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited January 3, 2024).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited January 3, 2024).
[3] *Id*.
[4] National Institute of Mental Health (NIH), *Mental Illness*, https://www.nimh.nih.gov/health/statistics/mental-illness (last visited January 3, 2024).
[5] *Id*.
[6] Ch. 2001-191, Laws of Fla.
[7] Ch. 2008-243, Laws of Fla

DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state.[8]

Current Situation - Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[9] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[10] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[11] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[12] DCF must use performance-based contracts to award grants.[13]

There are several essential elements which make up a coordinated system of care, including:[14]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[15]

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and

[8] DCF, *Managing Entities,* available at https://www.myflfamilies.com/services/samh/prov/*d*ers/managing-entities, (last visited January 8, 2024).
[9] S. 394.9082(5)(d), F.S.
[10] S. 394.4573(1)(c), F.S.
[11] S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.
[12] *Id.*
[13] *Id.*
[14] S. 394.4573(2), F.S.
[15] S. 394.495(4), F.S

- Trauma-informed services for children who have suffered sexual exploitation.

DCF must define the priority populations which would benefit from receiving care coordination.[16] In defining priority populations, DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[17] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[18]

The Baker Act

The Florida Mental Health Act, commonly referred to as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[19] The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[20]

DCF is responsible for the operation and administration of the Baker Act, including publishing an annual Baker Act report. According to the Fiscal Year (FY) 2021-2022 Baker Act annual report, over 170,000 individuals were involuntarily examined under the Baker Act; of those, just over 11,600 individuals were 65 years of age or older. This age group is the most likely to include individuals with Alzheimer's disease or related dementia. It is important to note the number of Baker Acts per year decreased during FY 2018-2019, FY 2019-2020, and FY 2020-2021, across all age groups.[21]

Rights of Patients

Current Situation

The Baker Act protects the rights of patients examined or treated for mental illness in Florida, including, but not limited to, the right to give express and informed consent for admission or treatment and the right to communicate freely and privately with persons outside a facility, unless the facility determines that such communication is likely to be harmful to the patient or others.[22]

Each patient entering treatment must be asked to give express and informed consent for admission or treatment.[23] If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment must be obtained from the patient's guardian or guardian advocate. If the patient is a minor, consent must be requested from the patient's guardian unless the minor is seeking outpatient crisis intervention services.[24] In situations where emergency medical treatment is needed and the patient or the patient's guardian or guardian advocate are unable to provide consent, the administrator of the facility may, upon the recommendation of the patient's

[16] S. 394.9082(3)(c), F.S.
[17] S. 394.9082(5)(b), F.S.
[18] S. 394.75(3), F.S.
[19] The Baker Act is contained in Part I of ch. 394, F.S.
[20] S. 394.459, F.S.
[21] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[22] Ss.394.459(3), and 394.459(5), F.S. Other patient rights include the right to dignity; treatment regardless of ability to pay; express and informed consent for admission or treatment; quality treatment; possession of his or her clothing and personal effects; vote in elections, if eligible; petition the court for a writ of habeas corpus to question the cause and legality of their detention in a receiving or treatment facility; and participate in their treatment and discharge planning. See, s. 394.459 (1)-11), F.S. Current law imposes liability for damages on those who violate or abuse patient rights or privileges. See, s. 394.459 (10), F.S.
[23] S. 394.459(3).
[24] S. 394.4784, F.S.

attending physician, authorize treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient.[25]

Currently, a facility must provide immediate patient access to a patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless such access would be detrimental to the patient or the patient exercises their right not to communicate or visit with the person.[26] If a facility restricts a patient's right to communicate or receive visitors, the facility must provide written notice of the restriction and the reasons for it to the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative.[27] A qualified professional[28] must document the restriction within 24 hours, and a record of the restriction and the reasons thereof must be recorded in the patient's clinical record. Under current law, a facility must review patient communication restrictions at least every three days.[29]

Effect of Bill – Rights of Patients

The bill authorizes the facility administrator to authorize emergency medical treatment for a patient upon the recommendation of the patient's licensed medical practitioner.[30]

If a facility restricts a patient's right to communicate, the bill requires a qualified professional to record the restriction and its underlying reasons in the patient's clinical file within 24 hours and to immediately serve the document of record to the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative.

Receiving Facilities and Involuntary Examination

Current Situation – Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[31] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a receiving facility.

Receiving facilities, often referred to as Baker Act receiving facilities, are public or private facilities designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[32] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[33] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[34] Currently, there are 126 DCF designed receiving facilities.[35]

Crisis Stabilization Units

[25] S. 394.459(3)(d), F.S.
[26] S. 394.459(5)(c), F.S.
[27] *S. 394.459(5)(d), F.S.*
[28] A qualified professional is a physician or a physician assistant, a psychiatrist licensed, a psychologist, or a psychiatric n urse. See s. 394.455(39), F.S.
[29] *Id*.
[30] The bill defines a "licensed medical practitioner" as a medical provider who is a physician licensed under chapters 458 or 459, an advanced practiced registered nurse, or a physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123, F.S.
[31] Ss. 394.4625 and 394.463, F.S.
[32] S. 394.455(40), F.S. This term does not include a county jail.
[33] S. 394.455(38), F.S
[34] R. 65E-5.400(2), F.A.C.
[35] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals brought to the unit under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services. CSUs provide services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs.[36] Individuals often enter the public mental health system through CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

Although involuntary examinations under the Baker Act have recently been decreasing statewide, the population of Florida continues to grow, and there are counties where the number of involuntary examinations remain the same or are slightly increasing, while some receiving facilities within communities are closing. There has been some demonstrated success with mobile response teams diverting individuals from the receiving facilities, resulting in those persons who are admitted to a receiving facility for an involuntary examination having higher acuity and longer lengths of stay.

In 2011, statute directed DCF to implement a demonstration project in circuit 18 to assess the impact of expanding the number of authorized CSU beds from 30 to 50. The facility in circuit 18 reported that by adding 20 additional beds, they were able to alleviate capacity issues within the county through 2021. The facility also reported that there are days that they exceed 100% capacity. Additionally, the facility reported that the bed capacity expansion has allowed them to serve clients with complex needs (e.g., clients served by APD).[37]

Current Situation – Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[38]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[39] or
- A physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[40]

Unlike the discretion afforded courts and medical professionals, current law mandates that law enforcement officers must initiate an involuntary examination of a person who appears to meet the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.[41] When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.[42] The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record. The report must also include all emergency contact information for the person that is readily accessible to the law enforcement officer, including

[36] S. 394.875, F.S.
[37] DCF, Agency Bill Analysis, (2023), on file with the House Children, Families, and Seniors Subcommittee.
[38] S. 394.463(1), F.S.
[39] S. 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[40] S. 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[41] S. 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[42] *Id.*

information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles.

Involuntary patients must be taken to either a public or a private facility that has been designated by DCF as a Baker Act receiving facility. Under the Baker Act, a receiving facility has up to 72 hours to examine an involuntary patient.[43] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility, to determine if the criteria for involuntary services are met.[44] Current law does not indicate when the examination period begins for an involuntary patient. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[45]

Within that 72-hour examination period, one of the following must happen:[46]

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to be placed and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

If the patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:[47]

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day and the petition for involuntary services must be filed no later than such date. If the receiving facility fails to file a petition at the close of the next working day, the patient must be released from the receiving facility upon documented approval from a psychiatrist or a clinical psychologist.
- Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day if a qualified professional documents that adequate discharge planning and procedures and approval from a psychiatrist or a clinical psychologist are not possible until the next working day.

The receiving facility may not release an involuntary examination patient without the documented approval of a psychiatrist or a clinical psychologist. However, if the receiving facility is owned or operated by a hospital or health system, or a nationally accredited community mental health center, a psychiatric nurse performing under the framework of an established protocol with a psychiatrist is permitted to release a Baker Act patient in specified community settings. However, a psychiatric nurse is prohibited from approving a patient's release if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. [48]

Current Situation - Baker Act Reporting Requirements

Section 394.461(4), F.S., directs facilities designated as public receiving or treatment facilities to report certain data to DCF on an annual basis. DCF must issue an annual report based on the data received, including individual facility data and statewide totals. The report is submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

[43] S. 394.463(2)(g), F.S.
[44] S. 394.463(2)(f), F.S.
[45] S. 394.463(2)(g), F.S.
[46] *Id*.
[47] S. 394.463(2)(g)4., F.S.
[48] S. 394.463(2)(f), F.S.

Section 394.463(2)(e), F.S., requires DCF to prepare and provide annual reports to the agency itself, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives. The annual reports analyze data obtained from ex parte orders, involuntary orders issued under the Baker Act, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients.[49] Current law does not provide a due date for the report.

Section 394.463(4), F.S., also requires DCF to submit reports detailing findings on repeated involuntary Baker Act examinations of minors using data submitted by receiving facilities.[50] DCF must analyze the data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school; identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student; study root causes for such patterns, trends, or repeated involuntary examinations; and make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations. The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered year.

Effect of Bill – Involuntary Examination

One of the criteria for involuntary examination requires that the person to be likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through the help of "willing" family members or friends. The bill amends this criteria to add that such family members or friends being considered for offering help also be able and responsible.

The bill authorizes, rather than requires as in current law, law enforcement officers to transport those who appear to meet Baker Act criteria to receiving facilities. This gives law enforcement officers the same discretion that courts and medical professionals have to initiate an involuntary examination. By removing the legal mandate to initiate an involuntary examination, there could be a reduction in involuntary examinations, especially in cases involving minors and schools. This may lead to greater use of alternatives to involuntary examinations, such as mobile response teams.

The bill removes the restriction prohibiting a psychiatric nurse from approving a patient's release from involuntary examination when the examination was initiated by a psychiatrist.

Effect of Bill – Receiving Facilities

The bill:

- Specifies that the 72 hour Baker Act examination period begins when a patient arrives at the receiving facility.
- Prohibits a receiving facility from releasing a patient from involuntary examination outside of the facility's ordinary business hours if the 72 hour examination period ends on a weekend or holiday.
- Removes facility bed caps for CSUs. This change will allow receiving facilities to expand to meet the need created by population growth, receiving facility closures, and longer lengths of stay.

The bill requires the court to dismiss a petition for involuntary services if the petitioner fails to file the petition within the 72 hour Baker Act examination period.

[49] S. 394.463(2)(e). F.S.
[50] S. 394.463(4), F.S.

Effect of Bill - Baker Act Reports

The bill amends the reporting requirements in s. 394.461, F.S., to require DCF to publish the report on designated public receiving and treatment facility data on the department's website.

The bill amends s. 394.463(2)(e), F.S., to require DCF to publish the annual reports analyzing ex parte, involuntary outpatient services, and involuntary inpatient placement orders, and the professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients on the agency's website by November 30 of each year and eliminates the current requirement for DCF to provide annual reports to the department itself.

The bill also amends s. 394.463(4), F.S., to requires DCF and the Agency for Health Care Administration to analyze service data collected on individuals who are high utilizers of crisis stabilization services provided in designated receiving facilities and identify patterns or trends and make recommendations to decrease avoidable admissions. The bill permits recommendations to be addressed in contracts with managing entities or with Medicaid managed medical assistance plans.

Involuntary Services

Involuntary services are defined as court-ordered outpatient services or inpatient placement for mental health treatment.[51]

Current Situation – Involuntary Outpatient Services

A person may be ordered to involuntary outpatient services upon a finding of the court that by clear and convincing evidence, all of the following factors are met:[52]

- The person is 18 years of age or older;
- The person has a mental illness;
- The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- The person has a history of lack of compliance with treatment for mental illness;
- The person has, within the immediately preceding 36 months:
    - Been involuntarily admitted to a receiving or treatment facility, or has received mental health services in a forensic or correctional facility, at least twice; or
    - Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others;
- The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
- The person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being;[53]
- It is likely that the person will benefit from involuntary outpatient services; and
- All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

A petition for involuntary outpatient services may be filed by the administrator of either a receiving facility or a treatment facility. [54] The petition must allege and sustain each of the criterion for involuntary

[51] S. 394.455(23), F. S.
[52] S. 394.4655(2), F.S.
[53] This factor is evaluated based on the person's treatment history and current behavior.
[54] S. 394.4655(4)(a), F.S.

outpatient services and be accompanied by a certificate recommending involuntary outpatient services by a qualified professional and a proposed treatment plan.[55]

The petition for involuntary outpatient services must be filed in the county where the patient is located. However, if the patient is being placed from a state treatment facility, the petition must be filed in the county where the patient will reside.[56] The petition must be based on the opinion of two professionals who have personally examined the individual within the preceding 72 hours.[57] When the petition has been filed, the clerk of the court must provide copies of the petition and the proposed treatment plan to DCF, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel.[58]

Once a petition for involuntary outpatient services has been filed with the court, the court must hold a hearing within five business days, unless a continuance is granted.[59] Under current law, the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[60] The court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in the patient's best interests and the patient's counsel does not object.[61] Otherwise, the patient must be present. The state attorney for the circuit in which the patient is located represents the state, rather than the petitioner, as the real party in interest in the proceeding.[62] The court must appoint the public defender to represent the person who is the subject of the petition, unless that person is otherwise represented by counsel.[63]

At the hearing on involuntary outpatient services, the court must consider testimony and evidence regarding the patient's competence to consent to treatment; if the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate.[64] If the court concludes that the patient meets the criteria for involuntary outpatient services, it must issue an order for those services.[65] The order must specify the duration of involuntary outpatient services, which may be up to 90 days, and the nature and extent of the patient's mental illness.[66] The order of the court and the treatment plan are to be made part of the patient's clinical record.[67]

If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services, but instead meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination.[68]

Current Situation - Involuntary Inpatient Placement

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that: [69]

- He or she is mentally ill and because of his or her mental illness:

[55] S. 394.4655(4)(b), F.S.
[56] S. 394.4655(4)(c), F.S.
[57] S. 394.4655(3)(a)1., F.S.
[58] *Id*.
[59] S. 394.4655(7)(a)1., F.S.
[60] S. 394.4655(7)(a)1., F.S.
[61] S. 394. 4655(7)(a)1, F.S.
[62] *Id*.
[63] S. 394.4655(5), F.S. This must be done within one court working day of filing of the petition.
[64] S. 394.4655(7)(d), F.S.
[65] S. 394.4655(7)(b)1., F.S.
[66] *Id*.
[67] *Id*.
[68] S. 394.4655(7)(c), F.S. Additionally, if the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to the Marchman Act, the court may order the person to be admitted for involuntary assessment pursuant to the statutory requirements of the Marchman Act.
[69] S. 394.467(1), F.S.

    - He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement or is unable to determine for himself or herself whether placement is necessary; and
    - He or she is incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services; and
    - Without treatment, is likely to suffer from neglect or refuse to care for himself or herself; and
    - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
    - There is a substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

The administrator of the receiving or treatment facility that is retaining a patient for involuntary inpatient treatment must file a petition for involuntary inpatient placement in the court in the county where the patient is located.[70] The petition must be based on the opinions of two professionals who have personally examined the individual within the past 72 hours.[71] Upon filing, the clerk of the court must provide copies to DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.[72] Unlike the procedures for involuntary outpatient services, current law does not require a proposed treatment plan to be filed with the petition for involuntary inpatient placement.

Current Situation - Involuntary Inpatient Placement Hearing

The court proceedings for involuntary inpatient placement closely mirror those for involuntary outpatient services.[73] However, the laws governing involuntary inpatient placement are silent regarding the court's order becoming part of the patient's clinical record. Once a petition for involuntary inpatient placement has been filed, the court must hold a hearing within five business days in the county or facility where the patient is located, unless a continuance is granted.[74] Presently, only the patient is entitled to a maximum four-week continuance, with the concurrence of their counsel.[75] Similar to the procedures for involuntary outpatient services, the court may waive a patient's presence from all or any portion of the hearing if it finds the patient's presence is not in their best interests, and the patient's counsel does not object.[76] Otherwise, the patient must be present.

Current law permits the court to appoint a magistrate to preside at the hearing, in general.[77] At the hearing, the state attorney must represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.[78] Although the state attorney has the evidentiary burden in Baker Act cases, current law does not require a facility to make the patient's clinical records available to the state attorney so that the state can evaluate and prepare its case before the hearing. Additionally, there is no requirement that the court allow testimony from family members regarding the patient's prior history and how it relates to their current condition.

If, at any time before the conclusion of the hearing, it appears to the court that the person does not meet the criteria for involuntary inpatient placement, but rather meets the criteria for involuntary outpatient services, the court may order the person evaluated for involuntary outpatient services.[79]

[70] S. 394.467(2) and (3), F.S.
[71] S. 394.467(2), F.S.
[72] S. 394.467(3), F.S.
[73] *See* s. 394.467(6) and (7), F.S.
[74] S. 394.467(6), F.S.
[75] S. 394.467(5), F.S.
[76] S. 394.467(6), F.S.
[77] *Id*.
[78] *Id*.
[79] S. 394.467(6)(c), F.S.

If the court concludes that the patient meets the criteria for involuntary inpatient placement, it has discretion to issue an order for involuntary inpatient services at a receiving facility for up to 90 days or in a state treatment facility[80] for up to six months.[81]

Current law prohibits a state treatment facility from admitting a civil patient unless he or she has undergone a transfer evaluation, the process by which the patient is evaluated for appropriateness of placement in a treatment facility.[82] Current law also requires the court to receive and consider the transfer evaluation's documented information before the involuntary placement hearing is held, but it does not specify that the evaluator must testify at the hearing in order for the court to consider any substantive information within it.[83] Under Florida law, if a court were to consider substantive information in the transfer evaluation without the evaluator testifying at the hearing, it would be a violation of the hearsay rule contained in Florida's Evidence Code.[84]

Current law requires the court's order to specify the nature and extent of the patient's illness and prohibits the court from ordering individuals with traumatic brain injuries or dementia who lack a co-occurring mental illness to be involuntarily committed to a state treatment facility.[85] However, there is currently no prohibition against involuntarily committing individuals with developmental disabilities who also lack a co-occurring mental illness to these facilities.

Current Situation - Remote Hearings

In response to the COVID-19 pandemic, on March 21, 2020, the Chief Justice of the Florida Supreme Court issued Supreme Court of Florida Administrative Order AOSC20-23, Amendment 2, authorizing courts to conduct hearings remotely. However, on January 8, 2022, Supreme Court of Florida Administrative Order AOSC21-17 was issued, requiring in-person hearings unless the facility where the individual is located is closed to hearing participants due to the facility's COVID-19 protocols or the individual waives the right to physical presence at the hearing.

Current Situation - Discharge Planning

Under current law, before a patient is released from a receiving or treatment facility, certain discharge planning procedures must be followed. Each facility must have discharge planning and procedures that include and document consideration of, at a minimum:

- follow-up behavioral health appointments,
- information on how to obtain prescribed medications, and
- information pertaining to available living arrangements, transportation, and recovery support services.[86]

Additionally, for minors, information related to the Suicide and Crisis Lifeline must be provided.

Effect of Bill - Involuntary Services

The process and criteria for involuntary outpatient services and involuntary inpatient placement are very similar. The bill combines these statutes and creates an "Involuntary Services" statute to remove duplicative functions, simplify procedures and to create a more streamlined and patient-tailored process

[80] A treatment facility is any state-owned, state-operated, or state-supported hospital, center, or clinic designated by DCF to provide mentally ill patients treatment and hospitalization that extends beyond that provided for by a receiving facility. Treatment facilities also include federal government facilities and any private facility designated by DCF. Only VA patients may be treated in federal facilities S. 394.455(48), F.S. A receiving facility is any public or private facility or hospital designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. County jails are not considered receiving facilities. S. 394.455(40), F.S.
[81] S. 394.467(6)(b), F.S.
[82] S. 394.461(2), F.S.
[83] *Id*.
[84] S. 90.802, F.S. The basic hearsay rule states that courts cannot rely on out-of-court, unsworn statements (written or spoken) as proof of the matter asserted in the statement.
[85] S. 394.467(6), F.S.
[86] S. 394.468, F.S.

for committing individuals to involuntary services. The new statute largely maintains current law for involuntary outpatient services and involuntary inpatient placement. However, the bill does make some substantive changes to the process, which are discussed below.

The bill allows those under age 18 access to all involuntary services. This will increase access to services, as current law required the individual be 18 or older for involuntary outpatient services.

The bill removes the involuntary outpatient services 36-month involuntary commitment criteria which required the person to have been committed to a receiving or treatment facility or received mental health services in a forensic or correctional facility within the preceding 36-month period.

The bill creates a single petition process for involuntary services. This gives the court more flexibility and authority to order a person to either involuntary outpatient services, involuntary inpatient placement, or a combination of both. The bill also creates a single certificate for petitioning for involuntary services. The bill requires a court order for both involuntary outpatient services and involuntary inpatient placement be included in the patient's clinical record.

The bill authorizes civil patients to be admitted to state treatment facilities without undergoing a transfer evaluation. This could result in a greater number of admissions to state treatment facilities. The bill also removes the requirement that the court receive and consider a transfer evaluation before a hearing for involuntary placement. Instead, it allows the state attorney to establish that a transfer evaluation was performed and that the document was properly executed by providing the court with a copy of the transfer evaluation before the close of the state's case. This change will likely improve court efficiencies as hearings will not need to be delayed because a transfer evaluation is unavailable before the hearing. The bill codifies current hearsay rules by specifying that the court may not consider substantive information in the transfer evaluation unless the evaluator testifies at the hearing.

The bill prohibits the court from ordering an individual with a developmental disability as defined under s. 393.063, F.S., who lacks a co-occurring mental illness, into a state treatment facility. This expands current law which prohibits such orders for persons with traumatic brain injury or dementia and ensures that limited state treatment facility beds remain for individuals who are appropriate for treatment.

The bill makes technical and conforming changes and updates cross references.

Effect of Bill - Involuntary Services Hearing

The bill expands the grounds under which a patient's presence at the hearing may be waived. Specifically, the bill authorizes the court to waive a patient's presence if the patient knowingly, intelligently and voluntarily waives the right to be present. However, the bill maintains the requirement that the patient's counsel have no objections for the waiver to take effect.

The bill states that magistrates may preside over hearings for the petition for involuntary inpatient placement and ancillary proceedings. The bill also allows the state attorney to have access to records to litigate at the hearing. However, the bill requires that the records remain confidential and may not be used for criminal investigation or prosecution purposes or any purpose other than civil commitment. Additionally, the bill requires the court to allow testimony deemed relevant from family members regarding the patient's prior history and how it relates to their current condition and from other specified individuals, including medical professions, which aligns this provision with the Marchman Act.

Effect of Bill - Remote Hearing

The bill allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference, upon a showing of good cause and if all parties consent. The bill further requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing.

Effect of Bill - Discharge Planning

The bill amends the discharge procedures to require receiving and treatment facilities to include in their discharge planning and procedures documentation of the patient's needs and actions to address those needs. The bill requires the facilities to refer patients being discharged to care coordination services if the patient meets certain criteria and to recovery support opportunities through coordinated specialty care programs, including, but not limited to, connection to a peer specialist.

During the discharge transition process, the bill requires the receiving facility to coordinate face-to-face or through electronic means, while in the presence of the patient, discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service.

To further enhance the discharge planning process, the bill requires receiving facilities to implement policies and procedures outlining strategies for how they will comprehensively address the needs of the individuals who demonstrate a high utilization of receiving facility services to avoid or reduce future use of crisis stabilization services. More specifically, the bill requires the provider to develop and include in discharge paperwork a personalized crisis prevention plan for the patient that identifies stressors, early warning signs of symptoms, and strategies to manage crisis.

The bill requires receiving facilities to have a staff member engage a family member, legal guardian, legal representative, or a natural support of the patient's in discharge planning and meet with them face to face or through other electronic means to review the discharge plan. Further, the bill provides direction to initiate a referral to an appropriate provider to continue care for instances where certain levels of care are not immediately available at discharge.

Health Care Practitioners

Current Situation

Current law authorizes an advanced practice registered nurse (APRN) who meets certain criteria to engage in autonomous practice and primary care practice without a supervisory protocol or supervision by a physician.[87] Physician assistants (PAs) are authorized to practice under the supervision of a physician with whom they have a working relationship with and may perform medical services that are delegated to them that are within the supervising physician's scope of practice.[88]

Chapters 394 and 916, F.S., only authorize physicians to perform certain clinical services within mental health facilities and programs. Many of these services, often relating the physical health care needs of the patients receiving psychiatric care, can lawfully be performed by APRNs and PAs outside of mental health facilities and programs. Recent changes to chapters 458 and 464, F.S., have allowed these medical practitioners more flexibility to work within their full scope of practice. However, these changes have not been made to chapters 394 and 916, F.S., governing mental health services in the community and in the criminal justice system. This has resulted in unnecessary limits to the scope of practice for APRNs and PAs under these chapters.

Effect of Bill – Health Care Practitioners

The bill amends s. 394.455, F.S., to define the term "licensed medical practitioner" to mean a medical provider who is a physician licensed under chapters 458 or 459, an advanced practiced registered nurse, or a physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123, F.S. This will allow additional licensed medical providers recognized by the Department of Health to provide clinical services within the current scope of practice for APRNs as defined in chapter 464, F.S. and PAs in accordance with s. 458.347, F.S.

[87] S. 464.0123, F.S.
[88] S. 458.347, F.S.

The bill makes necessary conforming changes in chapters 394 and 916 due to the statutory changes made by the bill.

Current Situation - Background Screening for Mental Health Care Personnel

Chapter 435, F.S., establishes standards procedures and requirements for criminal history background screening of prospective employees. There are two levels of background screening: level 1 and level 2. Level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[89] and may include criminal records checks through local law enforcement agencies.[90] A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.[91]

Mental health personnel are required to complete level 2 background screening. Mental health personnel include all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities who have direct contact with individuals held for examination or admitted for mental health treatment.[92]

Section 456.0135, F.S., requires physicians, physician assistants, nurses, and other specified medical professionals to undergo a level 2 background screening as part of the licensure process.[93] The appropriate regulatory board reviews the background screening results to determine if the applicant or licensee has any offenses that would disqualify them from state licensure. A health care practitioner must also complete an additional level 2 background check as a condition of employment in mental health programs and facilities.

Effect of the Bill - Background Screening for Mental Health Care Personnel

The bill exempts licensed physicians and nurses who undergo background screening at initial licensure and licensure renewal from the background screening requirements for employment for mental health and substance use programs when providing service within their scope of practice. Currently, these licensed medical professionals must undergo level 2 screening once for licensure and then again for employment purposes, which can cause delays for onboarding personnel. The bill will allow background screening for licensure of these medical professionals to satisfy employment screening when providing a service within their scope of practice.

Substance Abuse

Approximately, 48.7 million people in the U.S. aged 12 and older had a substance use disorder (SUD) in 2022.[94] It is estimated that 1.1 million Floridians have a substance use disorder.[95] Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[96] Abuse can result when a person uses a substance[97] in a way that is not intended or recommended, or because they are using more than prescribed. Drug abuse can cause individuals to experience one or

[89] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited January 4, 2024).
[90] S. 435.03(1), F.S.
[91] S. 435.04, F.S.
[92] S. 394.4572(1)(a), F.S.
[93] S. 456.0135, F.S.
[94] SAMHSA, *key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf, (last visited on January 5, 2024).
[95] Substance Abuse and Mental Health Administration, *Behavioral Health Barometer, Florida, Volume 6,* (2020), https://www.samhsa.gov/data/sites/default/files/reports/rpt32826/Florida-BH-Barometer_Volume6.pdf (last visited January 5, 2024).
[96] *World Health Organization, Substance Abuse*, https://www.afro.who.int/health-topics/substance-abuse (last visited January 5, 2024).
[97] Substances can include alcohol and other drugs (illegal or not), as well as substances that are not drugs at all, such as coffee and cigarettes.

more symptoms of another mental illness or even trigger new symptoms.[98] Additionally, individuals with mental illness may abuse drugs as a form of self-medication. Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance use disorder.[99]

A substance use disorder is determined by specified criteria included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). According to the DSM-5, a SUD diagnosis is based on evidence of impaired control, social impairment, risky use, and pharmacological indicators (tolerance and withdrawal). Substance use disorders occur when the chronic use of alcohol or drugs cause significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[100] Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.[101] Brain imaging studies of persons with addiction show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[102] The most common substance use disorders in the U.S. are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[103]

According to the National Institute on Mental Health, a SUD is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.[104] SUDs may co-occur with other mental disorders.[105] Approximately 19.4 million adults in the U.S. have co-occurring disorders.[106] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[107]

The Marchman Act

In the early 1970s, the federal government furnished grants for states "to develop continuums of care for individuals and families affected by substance abuse."[108] The grants provided separate funding streams and requirements for alcoholism and drug abuse.[109] In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[110] In 1993, legislation combined chapters 396 and 397, F.S., into a single law, entitled the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[111] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

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[98] Robinson, L, Smith, M, and Segal, J, (October 2023). *Dual Diagnosis: Substance Abuse and Mental Health*, HealthGuide.org, available at https://www.helpguide.org/articles/addictions/substance-abuse-and-mental-health.htm#:~:text=Substance%20abuse%20may%20sharply%20increase,symptoms%20and%20delaying%20your%20recovery. (last visited January 5, 2024).
[99] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited January 5, 2024).
[100] Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited January 5, 2024).
[101] National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health (last visited January 5, 2024).
[102] National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited January 5, 2024).
[103] The Rural Health Information Hub, *Defining Substance Abuse and Substance Use Disorders*, available at https://www.ruralhealthinfo.org/toolkits/substance-abuse/1/definition (last visited January 5, 2024).
[104] National Institute of Mental Health, Substance Use and Co-Occurring Mental Disorders, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health (last visited January 5, 2024).
[105] *Id*.
[106] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2021 National Survey on Drug Use and Health,* (December 2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf, (last visited January 5, 2024).
[107] *Id*.
[108] Darran Duchene & Patrick Lane, *Fundamentals of the Marchman Act,* Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Program, *available at* http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited January 5, 2024).
[109] *Id.*
[110] *Id*.
[111] Ch. 93-39, Laws of Fla., codified in Chapter 397, F.S. Reverend Hal S. Marchman was an advocate for persons who suffer from alcoholism and drug abuse.

An individual may receive services under the Marchman Act through either voluntary[112] or involuntary admission.[113] The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization, and treatment can be obtained on an involuntary basis. The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider.[114] However, denial of addiction is a prevalent symptom of a SUD, creating a barrier to timely intervention and effective treatment.[115] As a result, a third party must typically provide a person the intervention needed to receive SUD treatment.[116]

Rights of Individuals

Current Situation

The Marchman Act protects the rights of individuals receiving substance abuse services in Florida, including, but not limited to the right to receive quality treatment at a state-funded facility, regardless of ability to pay and the right to counsel.[117] Under the Marchman Act, an individual must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she may apply immediately to the court to have an attorney appointed if he or she cannot afford one. If the individual is a minor, the minor's parent, legal guardian, or legal custodian may apply to the court to have an attorney appointed.[118]

Effect of Bill – Rights of Individuals

The bill amends s. 397.501, F.S., to require each individual receiving substance abuse services to be informed that the individual has the right to be represented by counsel in any judicial proceeding for involuntary substance abuse treatment.

Involuntary Admissions

Current Situation - Definitions

There are five involuntary admission procedures that can be broken down into two categories: non-court involved admissions and court involved admissions. Regardless of the nature of the proceedings, an individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment:[119]

- Has lost the power of self-control with respect to substance use; and
- The person's judgment has been so impaired because of substance abuse that he or she is incapable of appreciating the need for substance abuse services and of making a rational decision in regard to substance abuse services; or
- Without care or treatment, is likely to suffer from neglect or refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to their well-being and such harm is unavoidable through help of willing family members or friends; or

[112] *See* s. 397.601, F.S.
[113] *See* ss. 397.675 – 397.6978, F.S.
[114] *See* s. 397.601(1) and (2), F.S. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.
[115] SAMHSA, *key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf, (last visited on January 5, 2024).
[116] *Id*.
[117] S. 397.501, F.S.
[118] *Id.*
[119] S. 397.675, F.S.

- The person has either inflicted, attempted or threatened to inflict, or unless admitted, is likely to inflict physical harm on himself or herself or another.

Under the Marchman Act, to be "impaired" or "substance abuse impaired", a person must have a condition involving the use alcoholic beverages or any psychoactive or mood-altering substance, in a way that induces mental, emotional, or physical problems and causes socially dysfunctional behavior.[120] Examples of psychoactive or mood-altering substances include alcohol and illicit or prescription drugs, however, only alcohol is explicitly named under current law. Although having a substance use disorder often leads to being impaired or substance abuse impaired, it is not presently included in the "impaired" or "substance abuse impaired" definition.

Current Situation - Unlawful activities relating to assessment and treatment

It is unlawful to give false information for the purpose of obtaining emergency or other involuntary admission for assessment and treatment. It is also, unlawful to cause, conspire, or assist with conspiring: to have a person involuntarily admitted without a reason to believe the person is actually impaired; or to deny a person the right to treatment.[121]

Effect of Bill – Definitions

The bill updates and expands the definition of "impaired" or "substance abuse impaired" to include having a substance use disorder or a condition involving the use of illicit or prescription drugs. This change reflects current DSM-5 criteria and takes into consideration the use of drugs other than alcohol by substance abuse impaired individuals.

This change will likely grant courts more latitude in who may be ordered for involuntary treatment.

Effect of Bill - Unlawful activities relating to assessment and treatment

The bill amends s. 397.581, F.S., to make it unlawful for a person to *knowingly and willfully* (as opposed to just *willfully* under current law):

- Furnish false information for the purpose of obtaining emergency or other involuntary admission of another person;
- Cause or otherwise secure, or conspire with or assist another to cause or secure, any emergency or other involuntary procedure of another person under false pretenses; or
- Cause, or conspire with or assist another to cause, without lawful justification, the denial to any person of the right to involuntary procedures under chapter 397.

The bill expands the scope of law and makes it not only unlawful for an individual to knowingly and willfully provide false information, or to conspire or assist with conspiring, to obtain involuntary admission for his or herself, but also makes it unlawful for the individual to commit such acts against another person.

Current Situation - Non-Court Involved Involuntary Admissions

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act are:

- **Protective Custody**: This procedure is used by law enforcement officers when an individual is substance-impaired or intoxicated in public and is brought to the attention of the officer.[122]

[120] S. 397.311, F.S.
[121] S. 397.581, F.S. Committing an unlawful activity relating to assessment and treatment is misdemeanor of the first degree, punishable by law and by a fine not exceeding $5,000.
[122] Ss. 397.6771 – 397.6772, F.S. A law enforcement officer may take the individual to his or her residence, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to jail. Minors, however, cannot be take n to jail.

- **Emergency Admission**: This procedure permits an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility, or a detoxification facility for emergency assessment and stabilization. Individuals admitted for involuntary assessment and stabilization under this provision must have a physician's certificate for admission, demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.[123]
- **Alternative Involuntary Assessment for Minors**: This procedure provides a way for a parent, legal guardian, or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.[124]

Court Involved Involuntary Admissions

Current Situation – General Provisions

Under current law, courts have jurisdiction over involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse services to assess and stabilize an individual, and involuntary services,[125] which provides for long-term court-ordered substance abuse treatment. Both types of involuntary admissions involve filing a petition with the clerk of court in the county where the person is located, which may be different from where he or she resides. Current law permits the chief judge in Marchman Act cases to appoint a general or special magistrate to preside over all or part of the proceedings. Although this may include ancillary matters, such as writs of habeas corpus issued under the Marchman Act, this is not explicitly stated in current law.

Effect of Bill – Court Involved Involuntary Admissions

The bill revises language to specify that courts have jurisdiction over involuntary treatment petitions, rather than involuntary assessment and stabilization petitions. The bill also specifies that petitions may be filed with the clerk of court in the county where the subject of the petition resides instead of where he or she is located. The bill specifies that the chief judge may appoint a general or special magistrate to preside over all, or part, of the proceedings related to the petition or any ancillary matters, including but not limited to, writs of habeas corpus issued under the Marchman Act, rather than just over the proceedings.

Current Situation - Involuntary Assessment and Stabilization

A petition for involuntary assessment and stabilization must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary assessment and stabilization.[126] Once the petition is filed, the court issues a summons to the respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.[127] The court may appoint a magistrate to preside over all or part of the proceedings.[128]

After hearing all relevant testimony, the court determines whether the respondent meets the criteria for involuntary assessment and stabilization and must immediately enter an order that either dismisses the petition or authorizes the involuntary assessment and stabilization of the respondent.[129]

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[123] S. 397.679, F.S.
[124] S. 397.6798, F.S.
[125] The term "involuntary services" means "an array of behavioral health services that may be ordered by the court for a person with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders." S. 397.311(23), F.S. SB 12 (2016), ch. 2016-241, Laws of Fla., renamed "involuntary treatment" as "involuntary services" in ss. 397.695 – 397.6987, F.S., however some sections of the Marchman Act continue to refer to "involuntary treatment." For consistency, this analysis will use the term involuntary services.
[126] S. 397.6951, F.S.
[127] S. 397.6815, F.S. Under the ex parte order, the court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him or her to the nearest appropriate licensed service provider.
[128] S. 397.681, F.S., F.S.
[129] S. 397.6818, F.S.

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of 5 days[130] to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.[131] During that time, an assessment is completed on the individual.[132] The written assessment is sent to the court. Once the written assessment is received, the court must either: [133]

- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;
- Allow the individual to remain voluntarily at the licensed provider; or
- Hold the individual if a petition for involuntary services has been initiated.

Effect of the Bill - Involuntary Assessment and Stabilization

The bill repeals all provisions relating to court-ordered, involuntary assessments and stabilization under the Marchman Act and consolidates them into a new involuntary treatment process under ss. 397.6951-397.6975, F.S.

Current Situation - Involuntary Services

Involuntary services, synonymous with involuntary treatment, allows the court to require an individual to be admitted for treatment for a longer period if the individual meets the eligibility criteria for involuntary admission and has previously been involved in at least one of the four other involuntary admissions procedures within a specified period, including having been assessed by a qualified professional within five days.[134] Similar to a petition for involuntary assessment and stabilization, a petition for involuntary services must contain identifying information for all parties and attorneys and facts necessary to support the petitioner's belief that the respondent is in need of involuntary services.[135] Under current law, the petition must also contain the findings and recommendations of the qualified professional that performed the assessment.

An individual's spouse, legal guardian, any relative, or service provider, or any adult who has direct personal knowledge of the individual's substance abuse impairment or prior course of assessment and treatment may file a petition for involuntary services on behalf of the individual. If the individual is a minor, only a parent, legal guardian, or service provider may file such a petition.[136] Current law does not permit the court or clerk of court to waive or prohibit process service fees for indigent petitioners.

A hearing on a petition for involuntary services must be held within five days unless a continuance is granted.[137] A copy of the petition and notice of hearing must be provided to all parties and anyone else the court determines. Current law specifies that the court, not the clerk, must issue a summons to the person whose admission is sought.[138] However, typically the clerk of court, not the court, issues summons. Current law does not specify who must effectuate service (i.e., a law enforcement agency or

[130] If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of an individual within 5 days after the court's order, it may, within the original time period, file a request for an extension of time to complete its assessment. The court may grant additional time, not to exceed 7 days after the date of the renewal order, for the completion of the involuntary assessment and stabilization of the individual. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed, constitutes legal authority to involuntarily hold the individual for a period not to exceed 10 days in the absence of a court order to the contrary. S. 397.6821, F.S.
[131] S. 397.6811, F.S. The individual may also be ordered to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition.
[132] S. 397.6819, F.S., The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician before the end of the assessment period.
[133] S. 397.6822, F.S. The timely filing of a Petition for Involuntary Services authorizes the service provider to retain physical custody of the individual pending further order of the court.
[134] S. 397.693, F.S.
[135] S. 397.6951, F.S.
[136] S. 397.695 (5), F.S.
[137] S. 397.6955, F.S.
[138] S. 397.6955(3), F.S.

private process servers). Current law requires the respondent to be present, unless the court finds appearance to be harmful, in which case the court must appoint a guardian advocate to appear on the respondent's behalf.[139]

In a hearing for involuntary services, the petitioner must prove by clear and convincing evidence that:[140]

- The individual is substance abuse impaired and has a history of lack of compliance with treatment for substance abuse; and
- Because of such impairment the person is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:
    - Without services the individual is likely to suffer from neglect or refuse to care for himself or herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that there is a substantial likelihood that without services the individual will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or
    - The individual's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

At the hearing, the court must hear and review all relevant evidence, including the results of the involuntary assessment by a qualified professional, and either dismiss the petition or order the individual to receive involuntary services from his or her chosen licensed service provider, if possible and appropriate.[141]

If the court finds that the conditions for involuntary services have been proven, it may order the respondent to receive services from a publicly funded licensed service provider for up to 90 days.[142] If an individual continues to need involuntary services, at least 10 days before the 90-day period expires, the service provider can petition the court to extend services an additional 90 days.[143] A hearing must be then held within 15 days.[144] Unless an extension is requested, the individual is automatically released after 90 days.[145] Current law does not require facilities to offer discharge planning to assist the respondent with post-discharge care.

However, substance abuse treatment facilities other than addictions receiving facilities are not locked; therefore, individuals receiving treatment in such unlocked facilities under the Marchman Act may voluntarily leave treatment at any time, and the only legal recourse is for a judge to issue a contempt of court charge and impose brief jail time.[146] Current law does not permit courts to drug test respondents in Marchman Act cases.

Effect of the Bill - Involuntary Services

The bill amends the involuntary services criteria to allow the court to involuntarily admit an individual who *reasonably appears to meet*, rather than meets, the eligibility criteria and has previously been involved in at least one of the four other involuntary admissions procedures within a specified period. However, it amends the period for when the person has been assessed by a qualified professional to within the past 30 days, rather than five days.

The bill allows a petition to be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within 30 days before the petition was filed. The

[139] S. 397.6957(1), F.S.
[140] S. 397.6957(2), F.S.
[141] S. 397.6957(4), F.S.
[142] S. 397.697(1), F.S.
[143] S. 397.6975, F.S.
[144] *Id*.
[145] S. 397.6977, F.S.
[146] If the respondent leaves treatment, the facility will notify the court and a status conference hearing may be set. If the respondent does not appear at this hearing, a show cause hearing may be set. If the respondent does not appear for the show cause hearing, the court may find the respondent in contempt of court.

certificate must contain the professional's findings and, if the respondent refuses to submit to an examination, must document the refusal. The bill specifies that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

The bill amends the time period in which the court is required to schedule a hearing on the petition to within 10 court working days, rather than five, unless a continuance is granted. With the elimination of the separate involuntary assessment and stabilization procedures, this means the total time for when a court would have to hear a petition for involuntary assessment and stabilization (within 10 days) and a petition for involuntary services (within 5 days) has been reduced from 15 to 10 court working days under the consolidated procedure.

The bill specifies that the clerk, rather than the court, must issue the summons to the respondent and requires a law enforcement agency to effectuate service for the initial hearing, unless the court authorizes disinterested private process servers to serve parties. The bill authorizes the court to waive or prohibit service of process fees for respondents deemed indigent under current law.

In light of the consolidation of the court involved involuntary admission procedures, the bill provides that, in the case of an emergency, or when upon review of the petition the court determines that an emergency exists, the court may rely exclusively upon the contents of the petition and, without an attorney being appointed, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending. The court may further order a law enforcement officer or other designated agent of the court to:

- Take the respondent into custody and deliver him or her to either the nearest appropriate licensed service provider or a licensed service provider designated by the court to be evaluated; and
- Serve the respondent with the notice of hearing and a copy of the petition.

In such instances, the bill requires a service provider to promptly inform the court and parties of the respondent's arrival and refrain from holding the respondent for longer than 72 hours of observation thereafter, unless:

- The service provider seeks additional time in accordance with the law and the court, after a hearing, grants that motion;
- The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which will serve to extend the amount of time the respondent may be held for observation until the issue is resolved; or
- The original or extended observation period ends on a weekend or holiday, in which case the provider may hold the respondent until the next court working day.

Under the bill, if the ex parte order was not executed by the initial hearing date, it is deemed void. If the respondent does not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets the Marchman Act commitment criteria and that a substance abuse emergency exists, the bill allows the court to issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:

- Must continue the case for no more than 10 court working days; and
- May order a law enforcement officer or other designated agent of the court to:
    - Take the respondent into custody and deliver him or her to be evaluated either by the nearest appropriate licensed service provider or by a licensed service provider designated by the court; and
    - If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

The bill requires the petitioner and the service provider to promptly inform the court that the respondent has been assessed so that the court can schedule a hearing as soon as is reasonable. The bill requires the service provider to serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. If the respondent has not been assessed within 90 days, the bill requires the court to dismiss the case.

The bill provides an exception to the requirement that a respondent be present at the hearing, allowing absence from the hearing if he or she knowingly, intelligently, and voluntarily waives their right to appear, or upon proof of service, the court finds that the respondent's presence is inconsistent with their best interests or will likely be harmful to the respondent.

To be consistent with the changes in the Baker Act, the bill allows for all witnesses to appear and testify remotely under oath at a hearing via audio-video teleconference, upon a showing of good cause and if all parties consent. The bill further requires any witness appearing remotely to provide all parties with all relevant documents by the close of business the day prior to the hearing. The bill requires the court to hear and review all relevant evidence, including testimony from family members familiar with the respondent's history and how it relates to the respondent's current condition.

The bill prohibits a respondent from being involuntarily ordered into treatment if a clinical assessment is not performed, unless the respondent is present in court and expressly waives the assessment. Outside of emergency situations, if the respondent is not, or previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it appears that the respondent qualifies for involuntary treatment services, the bill requires the court to issue an involuntary assessment and stabilization order to determine the correct level of treatment for the respondent. In Marchman Act cases where an assessment was attached to the petition, the bill allows the respondent to request, or the court on its own motion to order, an independent assessment by a court-appointed physician or another physician agreed to by the court and the parties.

An assessment order issued in accordance with the bill is valid for 90 days, and if the respondent is present or there is either proof of service or the respondent's whereabouts are known, the bill provides that the involuntary treatment hearing may be continued for no more than 10 court working days. Otherwise, the petitioner and the service provider are required to promptly inform the court that the respondent has been assessed in order for the court to schedule a hearing as soon as practicable. The bill mandates that the service provider serve the respondent, before his or her discharge, with the notice of hearing and a copy of the petition. The bill requires the assessment to occur before the new hearing date. However, if there is evidence indicating that the respondent will not voluntarily appear at the hearing, or is a danger to self or others, the bill permits the court to enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the new hearing date. As stated above, the bill requires the court to dismiss the case if the respondent still has not been assessed after 90 days.

Assessments conducted by a qualified professional under the bill must occur within 72 hours after the respondent arrives at a licensed service provider unless the respondent displays signs of withdrawal or a need to be either detoxified or treated for a medical condition. In such cases, the amount of time the respondent may be held for observation is extended until that issue is resolved. If the assessment is conducted by someone other than a licensed physician, the bill requires review by a licensed physician within the 72-hour period.

If the respondent is a minor, the bill requires the assessment to begin within the first 12 hours after the respondent is admitted, in alignment with the Baker Act, and the service provider may file a motion to extend the 72 hours of observation by petitioning the court in writing for additional time. The bill requires a service provider to provide copies of the motion to all parties in accordance with applicable confidentiality requirements. After the hearing, the bill permits the court to grant additional time or expedite the respondent's involuntary treatment hearing. However, the involuntary treatment hearing can only be expedited by agreement of the parties on the hearing date or if there is notice and proof of service. If the court grants the service provider's petition, the service provider is permitted to hold the respondent until its extended assessment period expires or until the expedited hearing date. In cases

where the original or extended observation period ends on a weekend or holiday, the provider is only permitted to hold the respondent until the next court working day.

The bill requires the qualified professional, in accordance with applicable confidentiality requirements, to provide copies of the completed report to the court and all relevant parties and counsel. The report is required to contain a recommendation on the level, if any, of substance abuse and any co-occurring mental health treatment the respondent may need. The qualified professional's failure to include a treatment recommendation results in the petition's dismissal.

The bill provides that the court may initiate involuntary examination proceedings at any point during the hearing if it has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to neglect or injure himself, herself, or another if not committed, or otherwise meets the involuntary commitment provisions covered under the Baker Act. The bill requires any treatment order to include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

The bill permits the court to order drug tests for respondents in Marchman Act cases. The bill expands who may file a petition to extend treatment to include the person who filed the petition for the initial treatment order if the petition includes supporting documentation from the service provider. The bill removes the current requirement that the petition be filed at least 10 days before the expiration of the current court-ordered treatment period. The bill also reduces the court's requirement for scheduling a hearing from 15 days to within 10 court working days of the petition to extend being filed.

The bill requires the treatment facility to implement discharge planning and procedures for a respondent's release from involuntary treatment services. In alignment with the bill's new Baker Act requirements, discharge planning and procedures must include and document the respondent's needs, and actions to address those needs, for, at a minimum:

- follow-up behavioral health appointments,
- information on how to obtain prescribed medications, and
- information pertaining to available living arrangements, transportation, and referral to recovery support opportunities, including but not limited to, connection to a peer specialist.

Substance Abuse Treatment in Florida

Current Situation

DCF provides treatment for substance abuse through a community-based provider system that offers detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence:[147]

- **Detoxification Services:** Detoxification focuses on the elimination of substance use. Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.
- **Treatment Services:** Treatment services[148] include a wide array of assessment, counseling, case management, and support services that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment.
- **Recovery Support:** Recovery support services, including transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, are offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.

[147] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/services/samh/treatment, (last visited January 5, 2024).
[148] *Id*. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child protective system, employment, increased earnings, and better health.

Licensed Bed Capacity for Substance Abuse Service Providers

Current Situation

DCF regulates substance abuse treatment providers, establishing licensure requirements and licensing service providers and individual service components under ch. 397, F.S., and rule 65D-30, F.A.C. Currently, there are over 2,800 DCF licensed substance abuse providers.[149] Licensed service components include a continuum of substance abuse prevention,[150] intervention,[151] and clinical treatment services, including, but not limited to:[152]

- Addictions receiving facilities;
- Detoxification;
- Intensive inpatient treatment;
- Residential treatment;
- Day or night treatment, including, day or night treatment with host homes, and community housing;
- Intensive outpatient treatment;
- Outpatient treatment;
- Continuing care;
- Intervention;
- Prevention; and
- Medication-assisted treatment for opiate addiction.

For licenses issued to addictions receiving facilities, inpatient detoxification, intensive inpatient treatment, and residential treatment, DCF must certify and include on the service provider's license, the licensed bed capacity for each facility.[153] The licensed bed capacity is the total bed capacity, [154] or total number of operational beds, within the facility. The service provider must notify DCF of any change in the provider's licensed bed capacity equal to or greater than 10 percent, within 24 hours of the change.[155] Upon notification DCF must update the service provider's license to reflect the increased licensed bed capacity.[156]

Effect of Bill - Licensed Bed Capacity for Substance Abuse Service Providers

The bill prohibits a service provider operating an addictions receiving facility or providing detoxification on a non-hospital inpatient basis from exceeding its licensed capacity by more than 10 percent. A service provider also may not exceed its licensed capacity for more than three consecutive working days or for more than 7 days in a month. This is similar to the requirements for crisis stabilization units under the Baker Act.

[149] DCF, *Agency Bill Analysis,* (2023), on file with the House Children, Families, and Seniors Subcommittee.
[150] S. 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles.
[151] S. 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related pr oblems.
[152] S. 397.311(26), F.S.
[153] *Id.*
[154] Bed capacity is total number of operational beds and the number of those beds purchased by DCF. DCF, *Substance Abuse and Mental Health Financial and Service Accountability Management System (FASAMS), Pamphlet 155-2 Chapter 8 Acute Care Data* (May 2021), available at https://www.myflfamilies.com/sites/default/files/2022-12/chapter_08_acute_care.pdf, (last visited January 8, 2024).
[155] *Id.*
[156] DCF, *Operating Procedures,* CF Operating Procedure No. 155-31 Mental Health/Substance Abuse, available at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-31_district_substance_abuse_licensing_and_regulatory_policies_and_procedures.pdf, (last visited January 8, 2024).

State Forensic System

Criminal Defendants and Competency to Stand Trial

Current Situation

The Due Process Clause of the 14th Amendment to the United State Constitution prohibits the states from trying and convicting criminal defendants who are incompetent to stand trial.[157] The states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[158] Defendants must be able to appreciate the range and nature of the charges and penalties that may be imposed, understand the adversarial nature of the legal process, and disclose to counsel facts pertinent to the proceedings. Defendants also must manifest appropriate courtroom behavior and be able to testify relevantly.[159]

If a defendant is suspected of being mentally incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[160] If the motion is well-founded, the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[161] If the defendant is found to be mentally competent, the criminal proceeding resumes.[162] If the defendant is found to be mentally incompetent to proceed, the proceeding may not resume unless competency is restored.[163]

Involuntary Commitment of a Defendant Adjudicated Incompetent

Current Situation

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism, and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed due to mental illness[164] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil[165] and forensic[166] treatment facilities by the circuit court.[167] However, in lieu of such commitment, the offender may be released on conditional release[168] by the circuit court if the person is not serving a prison sentence.[169] The

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[157] *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); *Bishop v. U.S.*, 350 U.S.961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); *Jones v. State*, 740 So.2d 520 (Fla. 1999).
[158] *Id*. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[159] *Id*. See also s. 916.12, 916.3012, and 985.19, F.S.
[160] Rule 3.210, Fla.R.Crim.P.
[161] *Id*.
[162] Rule 3.212, Fla.R.Crim.P.
[163] *Id*.
[164] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." S. 916.12(1), F.S.
[165] A "civil facility" is a mental health facility established within the Department of Children and Families (DCF) or by contract with DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S. The DCF oversees two state-operated forensic facilities, Florida State Hospital and North Florida Evaluation and Treatment Center, and two privately-operated, maximum security forensic treatment facilities, South Florida Evaluation and Treatment Center and Treasure Coast Treatment Center.
[166] S. 916.106(10), F.S.
[167] S. 916.13, 916.15, and 916.302, F.S.
[168] Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.
[169] S. 916.17(1), F.S.

committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[170]

A civil facility is, in part, a mental health facility established within DCF or by contract with DCF to serve individuals committed pursuant to ch. 394, F.S., and defendants pursuant to ch. 916, F.S., who do not require the security provided in a forensic facility.[171]

A forensic facility is a separate and secure facility established within DCF or the Agency for Persons with Disabilities (APD) to service forensic clients committed pursuant to ch. 916, F.S.[172] A separate and secure facility means a security-grade building for the purpose of separately housing individuals with mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed from non-forensic residents.[173]

A court may only involuntarily commit a defendant adjudicated incompetent to proceed for treatment upon finding, based on clear and convincing evidence, that:[174]

- The defendant has a mental illness and because of the mental illness:
    - The defendant is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, the defendant is likely to suffer from neglect or refuse to care for herself or himself and such neglect or refusal poses a real and present threat of substantial harm to the defendant's well-being; or
    - There is a substantial likelihood that in the near future the defendant will inflict serious bodily harm on herself or himself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm.
- All available, less restrictive treatment alternatives, including treatment in community residential facilities or community inpatient or outpatient settings, which would offer an opportunity for improvement of the defendant's condition have been judged to be inappropriate; and
- There is a substantial probability that the mental illness causing the defendant's incompetence will respond to treatment and the defendant will regain competency to proceed in the reasonably foreseeable future.

If a person is committed pursuant to chapter 916, F.S., the administrator at the commitment facility must submit a report to the court: [175]

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.

Incompetent and Non-Restorable Defendants

If after being committed, the defendant does not respond to treatment and is deemed non-restorable, the administrator of the commitment facility must notify the court by filing a report in the criminal case.[176] Those who are found to be non-restorable must be civilly committed or released.[177]

[170] S. 916.16(1), F.S.
[171] S. 916.106(4), F.S.
[172] S. 916.106(10), F.S. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have be en involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents.
[173] *Id*.
[174] S. 916.13(1), F.S.
[175] S. 916.13(2), F.S.
[176] S. 916.13(2)(b), F.S.
[177] *Mosher v. State*, 876 So.2d 1230 (Fla. 1st DCA 2004).

Current Situation - Non-Restorable Competency

An individual's competency is considered non-restorable when it is not likely that he or she will regain competency in the foreseeable future.[178] DCF must make every effort to restore the competency of those committed pursuant to chapter 916, F.S., as incompetent to proceed. To ensure that all possible treatment options have been exhausted, all competency restoration attempts in less restrictive, step-down facilities should be considered prior to making a recommendation of non-restorability, particularly for individuals with violent charges.

Individuals who are found to be non-restorable in less than five years of involuntary commitment under section 916.13, F.S., require civil commitment proceedings or release. After an evaluator of competency has completed a competency evaluation and determined that there is not a substantial probability of competency restoration in the current environment in the foreseeable future, the evaluator must notify the appropriate recovery team[179] coordinator that the individual's competency does not appear to be restorable.

After notification, the recovery team's psychiatrist and clinical psychologist members must complete an independent evaluation to examine suitability for involuntary placement. Once the evaluation to examine suitability for involuntary placement is complete, the recovery team meets to consider the following:[180]

- Mental and emotional symptoms affecting competency to proceed;
- Medical conditions affecting competency to proceed;
- Current treatments and activities to restore competency to proceed;
- Whether relevant symptoms and conditions are likely to demonstrate substantive improvement;
- Whether relevant and feasible treatments remain that have not been attempted, including competency restoration training in a less restrictive, step-down facility; and
- Additional information as needed (including barriers to discharge, pending warrants and detainers, dangerousness, self-neglect).

The recovery team must document the team meeting and considerations for review, and, if applicable, the extent to which the individual meets the criteria for involuntary examination pursuant to s. 394.463, F.S., or involuntary inpatient placement pursuant to s. 394.467(1), F.S. Each member of the recovery team must provide a recommendation for disposition. Individuals with competency reported as non-restorable may be considered, as appropriate, for recommendations of release without legal conditions or involuntary examination or inpatient placement.[181]

Current Situation - Competency Evaluation Report

Following the completion of the competency evaluation, the evaluation to examine suitability for involuntary placement, and consideration of restorability, the evaluator of competency must complete a

[178] DCF Operating Procedures No. 155-13, *Mental Health and Substance Abuse: Incompetent to Proceed and Non-Restorable Status*, September 2021, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-13_incompetence_to_proceed_and_non-restorable_status.pdf (last visited March 13, 2023).

[179] A recovery team is an assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member and other treatment professionals commensurate with the resident's needs, goals, and preferences. DCF Operating Procedures No. 155-16, *Recovery Planning and Implementation in Mental Health Treatment Facilities*, May 16, 2019, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-16_recovery_planning_and_implementation_in_mental_health_treatment_facilities.pdf (last visited March 20, 2023).

[180] *Id*.

[181] Chapter 394, F.S., or Mosher v. State, 876 So. 2d 1230 (Fla. 1st DCA 2004).

competency evaluation report to the circuit court.[182] A competency evaluation report to the circuit court is a standardized mental health document that addresses relevant mental health issues and the individual's clinical status regarding competence to proceed. The report is completed, pursuant to s. 916.13(2), F.S., and DCF Operating Procedure 155-19 (Evaluation and Reporting of Competency to Proceed).[183] The operating procedures provide guidelines for the format and minimal content that must be included in the report. Evaluators may add other relevant and appropriate information as necessary to report on the individual's status and needs.[184] The report must include the following:

- A description of mental, emotional, and behavioral disturbances;
- An explanation to support the opinion of incompetence to proceed;
- The rationale to support why the individual is unlikely to gain competence to proceed in the foreseeable future;
- A clinical opinion that the individual no longer meets the criteria for involuntary forensic commitment pursuant to s. 916.13, F.S.; and
- A recommendation whether the individual meets the criteria for involuntary examination pursuant to s. 394.463, F.S.

In order for a criminal court to order an involuntary examination under the Baker Act, there must be sworn evidence that the defendant is believed to meet the Baker Act criteria. Reports from mental health treatment facilities, such as the competency evaluation report, provide the court with sufficient basis/evidence to enter an order for involuntary examination. These reports may be sworn upon request of the court.[185]

A competency evaluation report is used in the process of a forensic commitment becoming a civil commitment. However, to be considered in a criminal court proceeding as evidence that the defendant meets Baker Act criteria, the report must be sworn. Currently, competency evaluation reports are not sworn.

Current Situation - Civil Commitment after Determination of Non-Restorable Defendant

Civil commitment is initiated in accordance with Part I of Chapter 394, F.S. The procedures in that part ensure the due process rights of a person are protected and require examination of a person believed to meet Baker Act criteria at a designated receiving facility.

If a non-restorable defendant is returned to court in accordance with ch. 916, F.S., the criminal court has authority to enter an order for involuntary Baker Act examination, and the defendant is taken to the nearest receiving facility. If found to meet criteria, a separate civil case is opened and the criminal case may be dismissed.[186]

Effect of Bill - Involuntary Commitment of a Defendant Adjudicated Incompetent

Current law requires DCF to conduct a competency evaluation and submit a report to the circuit court, upon determination that a defendant will not, or is unlikely to, regain competency to proceed. The bill requires DCF to submit this report within 30 days of the determination. The bill also requires the report to be sworn and provided to counsel in addition to the court. Further, the bill establishes the minimum information that must be included in the competency evaluation report. The minimum reporting requirements are current DCF procedures in which the bill codifies into law, except that the bill authorizes the defendant to be considered for involuntary services, rather than an involuntary

[182] DCF's Operating Procedure 155-19, *Evaluation and Reporting of Competency to Proceed*, February 15, 2019, at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-19_evaluation_and_reporting_of_competency_to_proceed.pdf (last visited March 20, 2023).
[183] *Id*.
[184] *Id*.
[185] DCF, *Agency Bill Analysis HB 201 (2023), p. 2 (on file with the House Children Families, & Seniors Subcommittee).*
[186] S.916.145, F.S.

examination.[187] The report must include, at a minimum, the following information regarding the defendant:

- A description of mental, emotional, and behavioral disturbances;
- An explanation to support the opinion of incompetency to proceed;
- The rationale to support why the defendant is unlikely to gain competence to proceed in the foreseeable future;
- A clinical opinion regarding whether the defendant no longer meets the criteria for involuntary forensic commitment; and
- A recommendation on whether the defendant meets the criteria for involuntary services pursuant to s. 394.467, F.S.

These provisions ensure that the appropriate report is submitted to the court to initiate the process of moving a forensic commitment to a civil commitment. They also ensure that all relevant information is received timely and that the court may respond to the information in a timely manner.

The bill authorizes a defendant, who meets the criteria for involuntary examination as determined by an independent clinical opinion, to appear remotely for the hearing. The bill also authorized the remote appearance of witnesses.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.4572, relating to screening of mental health personnel.
Section 3: Amends s. 394.459, F.S., relating to rights of patients.
Section 4: Amends s. 394.4598, F.S., relating to guardian advocate.
Section 5: Amends s. 394.4599, F.S., relating to notice.
Section 6: Amends s. 394.461, F.S., relating to designation of receiving and treatment facilities and receiving systems.
Section 7: Amends s. 394, 4615, F.S., relating to clinical records; confidentiality.
Section 8: Amends s. 394.462, F.S., relating to transportation.
Section 9: Amends s. 394.4625, F.S., relating to voluntary admissions.
Section 10: Amends s. 394.463, F.S., relating to involuntary examination.
Section 11: Amends s. 394.4655, F.S., relating to involuntary outpatient services.
Section 12: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 13: Amends s. 394.468, F.S., relating to admission and discharge procedures.
Section 14: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 15: Amends s. 394.496, F.S., relating to service planning.
Section 16: Amends s. 394.499, F.S., relating to integrated children's crisis stabilization unit/juvenile addictions receiving facility services.
Section 17: Amends s. 394.875, F.S., relating to crisis stabilization units.
Section 18: Amends. S. 394.9085, F.S., relating to behavioral provider liability.
Section 19: Amends s. 397.305, F.S., relating to legislative findings, intent, and purpose.
Section 20: Amends s. 397.311, F.S., relating to definitions.
Section 21: Amends s. 397.401, F.S., relating to license required; penalty; injunction; rules waivers.
Section 22: Amends s. 397.4073, F.S., relating to personnel background checks; requirements and exceptions.
Section 23: Amends s. 397.501, F.S., relating to rights of individuals.
Section 24: Amends s. 397.581, F.S., relating to unlawful activities relating to assessment and treatment; penalties.
Section 25: Amends s. 397.675, F.S., relating to criteria for involuntary admissions.

[187] *Id*, note 26.

Section 26: Amends s. 397.6751, F.S., relating to service provider responsibilities regarding involuntary admissions.
Section 27: Amends s. 397.681, F.S., relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.
Section 28: Amends s. 397.693, F.S., relating to involuntary treatment.
Section 29: Amends s. 397.695, F.S., relating to involuntary services; persons who may petition.
Section 30: Amends s. 397.6951, F.S., relating to contents of petition for involuntary services.
Section 31: Amends s. 397.6955, F.S., relating to duties of court upon filing of petition for involuntary services.
Section 32: Amends s. 397.6818, F.S., relating to court determination.
Section 33: Amends s. 397.6957, F.S., relating to hearing on petition for involuntary services.
Section 34: Amends s. 397.6975, F.S., relating to extension of involuntary services period.
Section 35: Amends s. 397.6977, F.S., relating to disposition of individual upon completion of involuntary services.
Section 36: Repeals s. 397.6811, F.S., relating to involuntary assessment and stabilization.
Section 37: Repeals s. 397.6814, F.S., relating to involuntary assessment and stabilization; contents of petition.
Section 38: Repeals s. 397.6815, F.S., relating to involuntary assessment and stabilization; procedure.
Section 39: Repeals s. 397.6819, F.S., relating to involuntary assessment and stabilization; responsibility of licensed service provider.
Section 40: Repeals s. 397.6821, F.S., relating to extension of time for completion of involuntary assessment and stabilization.
Section 41: Repeals s. 397.6822, F.S., relating to disposition of individual after involuntary assessment.
Section 42: Repeals s. 397.6978, F.S., relating to guardian advocate; patient incompetent to consent; substance abuse disorder.
Section 43: Amends s. 916.106, F.S., relating to definitions.
Section 44: Amends s. 916.13, F.S., relating to involuntary commitment of defendant adjudicated incompetent.
Section 45: Amends s. 40.29, F.S., relating to payment of due-process costs; reimbursement for petitions and orders.
Section 46: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 47: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 48: Amends s. 744.2007, F.S., relating to powers and duties.
Section 49: Amends s. 916.107, F.S., relating to rights of forensic clients.
Section 50: Amends s. 916.15, F.S., relating to involuntary commitment of a defendant adjudicated not guilty by reason of insanity.
Section 51: Provides an appropriation.
Section 52: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has a significant fiscal impact to DCF and the state court system as delineated below. The bill provides $50,000,000 to DCF with the flexibility to fund the various provisions of the bill as there is an impact to the department and among providers that offer different behavioral health services.

- Reporting Requirements- DCF will be required to create and publish a report on Marchman Act services. The bill also requires DCF and the Agency for Health Care Administration to analyze the service data collected on individuals who are high users of crisis stabilization services. There is a resulting workload cost associated with these provisions.

- Involuntary Services- The bill provides judges with greater flexibility regarding the type of involuntary services to which to order a person, rather than being required to order the specific services for which the petition was filed or no services at all. This is likely to increase demand for involuntary outpatient services, as these services have lower utilization rates.

- Marchman Act Services- The bill makes it easier for family and friends of individuals with substance use disorder to successfully file pro se for Marchman Act services by streamlining the complicated two-petition process. This may result in increased demand for substance abuse treatment services as judges act on these petitions to order individuals into those services.

- Discharge Planning- The bill modifies the discharge procedures for receiving facilities by requiring the referral of patients to follow-up supports and services; face-to-face or electronic interaction with the patient and persons in their support system to communicate about follow-up care; and development of a personalized crisis prevention plan for the patient in an effort to mitigate repeated utilization of receiving facility services. There is an expected workload increase to the facilities to implement these provisions.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not provide rulemaking authority to implement the bill. However, the department has sufficient rulemaking authority to comply with the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 24, 2024, the Health Care Appropriations Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Revised discharge requirements by:
  - requiring a referral to care coordination only if the person needs the service,
  - removing the requirement for a masters' level or licensed staff member to handle the discharge meeting with the patient and family,
  - requiring facility staff to seek to engage the patient's family and friends, rather than requiring the staff member to engage them, and
  - removing the requirement for a receiving facility to coordinate ongoing treatment or make appointments.
- Appropriated the sum of $50,000,000 of recurring funds from the General Revenue Fund for the 2024-25 fiscal year to the Department of Children and Families to implement the bill.

The analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to mental health and substance abuse; amending s. 394.455, F.S.; defining the term "licensed medical practitioner"; conforming a provision to changes made by the act; amending s. 394.4572, F.S.; providing an exception to background screening requirements for certain licensed physicians and nurses; amending s. 394.459, F.S.; specifying a timeframe for recording restrictions in a patient's clinical file; requiring that such recorded restriction be immediately served on certain parties; conforming a provision to changes made by the act; amending s. 394.4598, F.S.; conforming a provision to changes made by the act; amending s. 394.4599, F.S.; revising written notice requirements relating to filing petitions for involuntary services; amending s. 394.461, F.S.; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's case-in-chief; prohibiting the court from considering substantive information in the transfer evaluation; providing an exception; revising reporting requirements; amending ss. 394.4615 and 394.462, F.S.; conforming provisions to changes made by the act; amending s. 394.4625, F.S.; revising

requirements relating to voluntary admissions to a facility for examination and treatment; conforming provisions to changes made by the act; amending s. 394.463, F.S.; authorizing, rather than requiring, law enforcement officers to take certain persons into custody for involuntary examinations; requiring written reports by law enforcement officers to contain certain information; removing a provision prohibiting a psychiatric nurse from approving the release of a patient under certain circumstances; revising the types of documents that the department is required to receive and maintain and that are considered part of the clinical record; requiring the department to post a specified report on its website; revising requirements for releasing a patient from a receiving facility; revising requirements for petitions for involuntary services; requiring the department and the Agency for Health Care Administration to analyze certain data, identify patterns and trends, and make recommendations to decrease avoidable admissions; authorizing recommendations to be addressed in a specified manner; requiring the department to publish a specified report on its website and submit such report to the Governor and Legislature by a certain date; amending s. 394.4655, F.S.; defining the term

"involuntary outpatient placement"; authorizing a specified court to order an individual to involuntary outpatient treatment; removing provisions relating to criteria, retention of a patient, and petition for involuntary outpatient services and court proceedings relating to involuntary outpatient services; amending s. 394.467, F.S.; providing definitions; revising requirements for ordering a person for involuntary services and treatment, petitions for involuntary service, appointment of counsel, and continuances of hearings, respectively; revising the conditions under which a court may waive the requirement for a patient to be present at an involuntary inpatient placement hearing; authorizing the court to permit witnesses to attend and testify remotely at the hearing through specified means; providing requirements for a witness to attend and testify remotely; requiring facilities to make certain clinical records available to a state attorney within a specified timeframe; specifying that such records remain confidential and may not be used for certain purposes; revising the circumstances under which a court may appoint a magistrate to preside over certain proceedings; requiring the court to allow certain testimony from specified persons; revising the length of time a court may require a patient to

receive services; requiring facilities to discharge patients when they no longer meet the criteria for involuntary inpatient treatment; prohibiting courts from ordering individuals with developmental disabilities to be involuntarily placed in a state treatment facility; requiring courts to refer such individuals, and authorizing courts to refer certain other individuals, to specified agencies for evaluation and services; providing requirements for treatment plan modifications, noncompliance with involuntary outpatient services, and discharge, respectively; revising requirements for the procedure for continued involuntary services and return to facilities, respectively; amending s. 394.468, F.S.; revising requirements for discharge planning and procedures; providing requirements for the discharge transition process; amending ss. 394.495 and 394.496, F.S.; conforming provisions to changes made by the act; amending s. 394.499, F.S.; revising eligibility requirements for children's crisis stabilization unit/juvenile addictions receiving facility services; amending s. 394.875, F.S.; removing a limitation on the size of a crisis stabilization unit; removing a requirement for the department to implement a certain demonstration project; amending s. 394.9085, F.S.;

conforming a cross-reference to changes made by the act; amending s. 397.305, F.S.; revising the purpose to include the most appropriate environment for substance abuse services; amending s. 397.311, F.S.; revising definitions; amending s. 397.401, F.S.; prohibiting certain service providers from exceeding their licensed capacity by more than a specified percentage or for more than a specified number of days; amending s. 397.4073, F.S.; providing an exception to background screening requirements for certain licensed physicians and nurses; amending s. 397.501, F.S.; revising notice requirements for the right to counsel; amending s. 397.581, F.S.; revising actions that constitute unlawful activities relating to assessment and treatment; providing penalties; amending s. 397.675, F.S.; revising the criteria for involuntary admissions for purposes of assessment and stabilization, and for involuntary treatment; amending s. 397.6751, F.S.; revising service provider responsibilities relating to involuntary admissions; amending s. 397.681, F.S.; revising where involuntary treatment petitions for substance abuse impaired persons may be filed; revising the portion of such proceedings over which a general or special magistrate may preside; providing an exception to a respondent's

right to counsel relating to petitions for involuntary treatment; revising the circumstances under which courts are required to appoint counsel for respondents without regard to respondents' wishes; renumbering and amending s. 397.693, F.S.; revising the circumstances under which a person may be the subject of court-ordered involuntary treatment; renumbering and amending s. 397.695, F.S.; authorizing the court or clerk of the court to waive or prohibit any service of process fees for petitioners determined to be indigent; renumbering and amending s. 397.6951, F.S.; revising the information required to be included in a petition for involuntary treatment services; authorizing a petitioner to include a certificate or report of a qualified professional with such petition; requiring such certificate or report to contain certain information; requiring that certain additional information be included if an emergency exists; renumbering and amending s. 397.6955, F.S.; revising when the office of criminal conflict and civil regional counsel represents a person in the filing of a petition for involuntary services and when a hearing must be held on such petition; requiring a law enforcement agency to effect service for initial treatment hearings; providing an exception; amending

s. 397.6818, F.S.; authorizing the court to take certain actions and issue certain orders regarding a respondent's involuntary assessment if emergency circumstances exist; providing a specified timeframe for taking such actions; amending s. 397.6957, F.S.; expanding the exemption from the requirement that a respondent be present at a hearing on a petition for involuntary treatment services; authorizing the court to order drug tests and to permit witnesses to attend and testify remotely at the hearing through certain means; removing a provision requiring the court to appoint a guardian advocate under certain circumstances; prohibiting a respondent from being involuntarily ordered into treatment unless certain requirements are met; providing requirements relating to involuntary assessment and stabilization orders; providing requirements relating to involuntary treatment hearings; requiring that the assessment of a respondent occur before a specified time unless certain requirements are met; authorizing service providers to petition the court in writing for an extension of the observation period; providing service requirements for such petitions; authorizing the service provider to continue to hold the respondent if the court grants the petition; requiring a qualified

professional to transmit his or her report to the clerk of the court within a specified timeframe; requiring the clerk of the court to enter the report into the court file; providing requirements for the report; providing that the report's filing satisfies the requirements for release of certain individuals if it contains admission and discharge information; providing for the petition's dismissal under certain circumstances; authorizing the court to order certain persons to take a respondent into custody and transport him or her to or from certain service providers and the court; revising the petitioner's burden of proof in the hearing; authorizing the court to initiate involuntary proceedings and have the respondent evaluated by the Agency for Persons with Disabilities under certain circumstances; requiring that, if a treatment order is issued, it must include certain findings; amending s. 397.6975, F.S.; authorizing certain entities to file a petition for renewal of an involuntary treatment services order; revising the timeframe during which the court is required to schedule a hearing; amending s. 397.6977, F.S.; providing requirements for discharge planning and procedures for a respondent's release from involuntary treatment services; repealing ss.

397.6811, 397.6814, 397.6815, 397.6819, 397.6821, 397.6822, and 397.6978, F.S., relating to involuntary assessment and stabilization and the appointment of guardian advocates, respectively; amending s. 916.106, F.S.; providing a definition for the term "licensed medical practitioner"; amending s. 916.13, F.S.; requiring the Department of Children and Families to complete and submit a competency evaluation report to the circuit court to determine if a defendant adjudicated incompetent to proceed meets the criteria for involuntary civil commitment if it is determined that the defendant will not or is unlikely to regain competency; defining the term "competency evaluation report to the circuit court"; requiring a qualified professional to sign such report under penalty of perjury; providing requirements for such report; authorizing a defendant who meets the criteria for involuntary examination and court witnesses to appear remotely for a hearing; amending ss. 40.29, 409.972, 464.012, 744.2007, 916.107, and 916.15 F.S.; conforming provisions to changes made by the act; providing an appropriation; providing an effective date.

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

Section 1. Subsections (26) through (50) of section 394.455, Florida Statutes, are renumbered as subsections (27) through (51), respectively, subsection (23) is amended, and a new subsection (26) is added to that section, to read:

394.455 Definitions.—As used in this part, the term:

(23) "Involuntary examination" means an examination performed under s. 394.463, s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811~~ to determine whether a person qualifies for involuntary services.

(26) "Licensed medical practitioner" means a medical provider who is a physician licensed under chapter 458 or chapter 459 or an advanced practice registered nurse or physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123.

Section 2. Paragraph (e) is added to subsection (1) of section 394.4572, Florida Statutes, to read:

394.4572 Screening of mental health personnel.—

(1)

(e) Any licensed physician or nurse who requires background screening by the Department of Health during initial licensure and the renewal of licensure is not subject to background screening pursuant to this section if he or she is providing a service that is within the scope of his or her

licensed practice.

Section 3. Paragraph (d) of subsection (3) and paragraph (d) of subsection (5) of section 394.459, Florida Statutes, are amended to read:

394.459 Rights of patients.—

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.—

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's licensed medical practitioner ~~attending physician~~, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(d) If a patient's right to communicate with outside persons; receive, send, or mail sealed, unopened correspondence; or receive visitors is restricted by the facility, a qualified professional must record the restriction and its underlying reasons in the patient's clinical file within 24 hours. The notice of the restriction must immediately ~~written notice of such restriction and the reasons for the restriction shall~~ be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative. ~~A qualified professional must document any restriction within 24 hours, and such restriction shall be recorded on the patient's clinical~~

~~record with the reasons therefor.~~ The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 3 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (e).

Section 4. Subsection (3) of section 394.4598, Florida Statutes, is amended to read:

394.4598 Guardian advocate.—

(3) A facility requesting appointment of a guardian advocate must, prior to the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's licensed medical practitioner ~~physician~~ in person, if at all possible, and by telephone, if not. The decision of the guardian

advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.

Section 5. Paragraph (d) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(d) The written notice of the filing of the petition for involuntary services for an individual being held must contain the following:

1. Notice that the petition for:

a. Involuntary services ~~inpatient treatment~~ pursuant to s. 394.467 has been filed with the circuit court and the address of such court ~~in the county in which the individual is hospitalized and the address of such court~~; or

b. Involuntary outpatient services pursuant to s. 394.467 ~~s. 394.4655~~ has been filed with the criminal county court, as defined in s. 394.4655(1), ~~or the circuit court, as applicable, in the county in which the individual is hospitalized~~ and the address of such court.

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to

testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

Section 6. Subsection (2) and paragraph (d) of subsection (4) of section 394.461, Florida Statutes, are amended to read:

394.461 Designation of receiving and treatment facilities and receiving systems.—The department is authorized to designate and monitor receiving facilities, treatment facilities, and receiving systems and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. The department may issue a conditional designation for up to 60 days to allow the implementation of corrective measures. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.

(2) TREATMENT FACILITY.—The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient shall not be admitted to a state treatment facility without previously undergoing a

transfer evaluation. Before the close of the state's case-in-chief in ~~a court~~ hearing for involuntary placement ~~in a state treatment facility~~, the state may establish that the transfer evaluation was performed and the document was properly executed by providing the court with a copy of the transfer evaluation. The court may not ~~shall receive and~~ consider the substantive information ~~documented~~ in the transfer evaluation unless the evaluator testifies at the hearing. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.

(4) REPORTING REQUIREMENTS.—

(d) The department shall issue an annual report based on the data required pursuant to this subsection. The report shall include individual facilities' data, as well as statewide totals. The report shall be posted on the department's website ~~submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives~~.

Section 7. Subsection (3) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has communicated to a service provider

a specific threat to cause serious bodily injury or death to an identified or a readily available person, if the service provider reasonably believes, or should reasonably believe according to the standards of his or her profession, that the patient has the apparent intent and ability to imminently or immediately carry out such threat. When such communication has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the criteria for involuntary services ~~outpatient placement~~ or for preparing the proposed treatment plan pursuant to s. 394.4655 or s. 394.467 ~~s. 394.4655~~, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider under s. 394.4655 or s. 394.467 ~~identified in s. 394.4655(7)(b)2.~~, in accordance

with state and federal law.

Section 8. Section 394.462, Florida Statutes, is amended to read:

394.462 Transportation.—A transportation plan shall be developed and implemented by each county in collaboration with the managing entity in accordance with this section. A county may enter into a memorandum of understanding with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into a memorandum of understanding for this purpose, the counties shall notify the managing entity and provide it with a copy of the agreement. The transportation plan shall describe methods of transport to a facility within the designated receiving system for individuals subject to involuntary examination under s. 394.463 or involuntary admission under s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811~~, and may identify responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan may rely on emergency medical transport services or private transport companies, as appropriate. The plan shall comply with the transportation provisions of this section and ss. 397.6772, 397.6795, ~~397.6822,~~ and 397.697.

(1) TRANSPORTATION TO A RECEIVING FACILITY.—

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person

into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the appropriate facility within the designated receiving system pursuant to a transportation plan.

(b)1. The designated law enforcement agency may decline to transport the person to a receiving facility only if:

a. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and

b. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

2. The entity providing transportation may seek reimbursement for transportation expenses. The party responsible for payment for such transportation is the person receiving the transportation. The county shall seek reimbursement from the following sources in the following order:

a. From a private or public third-party payor, if the person receiving the transportation has applicable coverage.

b. From the person receiving the transportation.

c. From a financial settlement for medical care,

treatment, hospitalization, or transportation payable or accruing to the injured party.

(c) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transport of the patient. Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(e) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(f) When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 or s. 397.675 and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.

(g) When any law enforcement officer has custody of a

person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination pursuant to s. 394.463, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan. Persons who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan.

(h) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person must first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the appropriate facility within the designated receiving system pursuant to a transportation plan. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the person where he or she is held.

(i) If the appropriate law enforcement officer believes

that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

(j) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.

(k) The appropriate facility within the designated receiving system pursuant to a transportation plan must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

(l) The appropriate facility within the designated receiving system pursuant to a transportation plan must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic screening or triage sufficient to refer the person to the appropriate services.

(m) Each law enforcement agency designated pursuant to paragraph (a) shall establish a policy that reflects a single set of protocols for the safe and secure transportation and

transfer of custody of the person. Each law enforcement agency shall provide a copy of the protocols to the managing entity.

(n) When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to facilities within the designated receiving system, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

(o) This section may not be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with s. 401.445.

(2) TRANSPORTATION TO A TREATMENT FACILITY.—

(a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting a voluntary or involuntary patient to a treatment facility, the transportation plan established by the governing board of the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities in a safe and dignified manner.

(b) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient.

Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(c) A company that contracts with one or more counties to transport patients in accordance with this section shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(d) County or municipal law enforcement and correctional personnel and equipment may not be used to transport patients adjudicated incapacitated or found by the court to meet the criteria for involuntary services ~~placement~~ pursuant to s. 394.467, except in small rural counties where there are no cost-efficient alternatives.

(3) TRANSFER OF CUSTODY.—Custody of a person who is transported pursuant to this part, along with related documentation, shall be relinquished to a responsible individual at the appropriate receiving or treatment facility.

Section 9. Paragraphs (a) and (f) of subsection (1) and subsection (5) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any adult ~~person 18 years of age or older~~ who applies by express and informed consent for admission or any minor

~~person age 17 or younger~~ whose parent or legal guardian applies for admission. Such person may be admitted to the facility if found to show evidence of mental illness and to be suitable for treatment, and:

1. If the person is an adult, is found~~,~~ to be competent to provide express and informed consent; or

2. If the person is a minor, the parent or legal guardian provides express and informed consent and the facility performs~~,~~ ~~and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or younger may be admitted only after~~ a clinical review to verify the voluntariness of the minor's assent.

(f) Within 24 hours after admission of a voluntary patient, the licensed medical practitioner ~~admitting physician~~ shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(5) TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a licensed medical practitioner ~~physician~~, clinical psychologist,

or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the ~~written~~ order of a licensed medical practitioner ~~physician~~, if it is determined that such treatment is necessary for the safety of the patient or others.

Section 10. Subsection (1), paragraphs (a), (e), (f), (g), and (h) of subsection (2), and subsection (4) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system

pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer may ~~shall~~ take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. A law enforcement officer transporting a person pursuant to this section ~~subparagraph~~ shall restrain the person in the least restrictive manner available and appropriate under the circumstances. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through

electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody and include all emergency contact information

required under subparagraph 2. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(e) The department shall receive and maintain the copies of ex parte orders, involuntary ~~outpatient~~ services orders issued pursuant to ss. 394.4655 and 394.467 ~~s. 394.4655, involuntary inpatient placement orders issued pursuant to s. 394.467~~, professional certificates, law enforcement officers'

reports, and reports relating to the transportation of patients. These documents shall be considered part of the clinical record, governed by the provisions of s. 394.4615. These documents shall be used to prepare annual reports analyzing the data obtained from these documents, without including the personal identifying information of the patient. ~~identifying patients, and~~ The department shall post the reports on its website and provide copies of such reports to the ~~department, the~~ President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives by November 30 of each year.

(f) A patient shall be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an

established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. ~~A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.~~ The release may be approved through telehealth.

(g) The examination period must be for up to 72 hours and begins when a patient arrives at the receiving facility. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court ~~if inpatient treatment is deemed necessary~~ or

with the criminal county court, as defined in s. 394.4655(1), as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. The ~~When a~~ petition ~~is to be filed for involuntary outpatient placement, it~~ shall be filed by one of the petitioners specified in s. 394.467, and the court shall dismiss an untimely filed petition ~~s. 394.4655(4)(a)~~. ~~A petition for involuntary inpatient placement shall be filed by the facility administrator.~~ If a patient's 72-hour examination period ends on a weekend or holiday, including the hours before the ordinary business hours on the morning of the next working day, and the receiving facility:

a. Intends to file a petition for involuntary services, such patient may be held at the ~~a receiving~~ facility through the next working day thereafter and the ~~such~~ petition ~~for involuntary services~~ must be filed no later than such date. If the ~~receiving~~ facility fails to file the ~~a~~ petition by ~~for involuntary services at~~ the ordinary close of business on the next working day, the patient shall be released from the receiving facility following approval pursuant to paragraph (f).

b. Does not intend to file a petition for involuntary services, the ~~a~~ receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge

planning and procedures in accordance with s. 394.468, and approval pursuant to paragraph (f), are not possible until the next working day.

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified in paragraph (g). The examination period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary ~~outpatient~~ services pursuant to s. 394.467 ~~s. 394.4655(2) or involuntary inpatient placement pursuant to s. 394.467(1)~~, the patient may be offered voluntary outpatient or inpatient services ~~or placement~~, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary ~~inpatient~~ services ~~or involuntary outpatient placement~~ must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before

stabilization if the requirements of s. 395.1041(3)(c) have been met.

(4) DATA ANALYSIS.—

(a) Using data collected under paragraph (2)(a) and s. 1006.07(10), the department shall, at a minimum, analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school; identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student; study root causes for such patterns, trends, or repeated involuntary examinations; and make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations.

(b) The department and the Agency for Health Care Administration shall analyze service data that the department and the agency collect on individuals who, as determined by the department and the agency, are high utilizers of crisis stabilization services provided in designated receiving facilities, and shall, at a minimum, identify any patterns or trends and make recommendations to decrease avoidable admissions. Recommendations may be addressed in the department's contracts with the behavioral health managing entities and in the agency's contracts with the Medicaid managed medical assistance plans.

(c) The department shall publish ~~submit~~ a report on its

findings and recommendations on its website and submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of each odd-numbered year.

Section 11. Section 394.4655, Florida Statutes, is amended to read:

394.4655 Involuntary outpatient services.—

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

(a) "Court" means a circuit court or a criminal county court.

(b) "Criminal county court" means a county court exercising its original jurisdiction in a misdemeanor case under s. 34.01.

(c) "Involuntary outpatient placement" means involuntary outpatient services as defined in s. 394.467, F.S.

(2) A criminal county court may order an individual to involuntary outpatient placement under s. 394.467. ~~CRITERIA FOR INVOLUNTARY OUTPATIENT SERVICES.—A person may be ordered to involuntary outpatient services upon a finding of the court, by clear and convincing evidence, that the person meets all of the following criteria:~~

~~(a) The person is 18 years of age or older.~~

~~(b) The person has a mental illness.~~

~~(c) The person is unlikely to survive safely in the community without supervision, based on a clinical~~

~~determination.~~

~~(d) The person has a history of lack of compliance with treatment for mental illness.~~

~~(e) The person has:~~

~~1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or~~

~~2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months.~~

~~(f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary or is unable to determine for himself or herself whether services are necessary.~~

~~(g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).~~

~~(h) It is likely that the person will benefit from involuntary outpatient services.~~

~~(i) All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.~~

~~(3) INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an~~

~~involuntary outpatient services certificate that authorizes the facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.~~

~~2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.~~

~~3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated~~

~~discharge criteria for terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined~~

~~the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.~~

~~(c)1. The administrator of the treatment facility shall provide a copy of the involuntary outpatient services certificate and a copy of the state mental health discharge form to the managing entity in the county where the patient will be residing. For persons who are leaving a state mental health treatment facility, the petition for involuntary outpatient services must be filed in the county where the patient will be residing.~~

~~2. The service provider that will have primary responsibility for service provision shall be identified by the designated department representative before the order for~~

~~involuntary outpatient services and must, before filing a petition for involuntary outpatient services, certify to the court whether the services recommended in the patient's discharge plan are available and whether the service provider agrees to provide those services. The service provider must develop with the patient, or the patient's guardian advocate, if appointed, a treatment or service plan that addresses the needs identified in the discharge plan. The plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in this chapter, who consults with, or is employed or contracted by, the service provider.~~

~~3. If the service provider certifies that the services in the proposed treatment or service plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(4) PETITION FOR INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a) A petition for involuntary outpatient services may be filed by:~~

~~1. The administrator of a receiving facility; or~~

~~2. The administrator of a treatment facility.~~

~~(b) Each required criterion for involuntary outpatient~~

~~services must be alleged and substantiated in the petition for involuntary outpatient services. A copy of the certificate recommending involuntary outpatient services completed by a qualified professional specified in subsection (3) must be attached to the petition. A copy of the proposed treatment plan must be attached to the petition. Before the petition is filed, the service provider shall certify that the services in the proposed plan are available. If the necessary services are not available, the petition may not be filed. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(c) The petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside. When the petition has been filed, the clerk of the court shall provide copies of the petition and the proposed treatment plan to the department, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel. A fee may not be charged for filing a petition under this subsection.~~

~~(5) APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary outpatient~~

~~services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of the appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary outpatient services. An attorney who represents the patient must be provided access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(6) CONTINUANCE OF HEARING.—The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.~~

~~(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. The court shall hold the hearing on involuntary outpatient services within 5 working days after the filing of the petition, unless a continuance is granted. The hearing must be held in the county where the petition is filed, must be as convenient to the patient as is consistent with orderly procedure, and must be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient and if the patient's~~

~~counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding.~~

~~2. The court may appoint a magistrate to preside at the hearing. One of the professionals who executed the involuntary outpatient services certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.~~

~~(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court shall issue an order for involuntary outpatient services. The court order shall be for a period of up~~

~~to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.~~

~~2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of~~

~~the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~3. If, in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~(c) If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services under this section but, instead, meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination under s. 394.463. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings are governed by chapter 397.~~

~~(d) At the hearing on involuntary outpatient services, the court shall consider testimony and evidence regarding the patient's competence to consent to services. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598. The guardian advocate shall be appointed or discharged in accordance with s. 394.4598.~~

~~(e) The administrator of the receiving facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient services. Such documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient,~~

~~and any evaluations of the patient performed by a psychologist or a clinical social worker.~~

~~(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider shall, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.~~

~~2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.~~

~~3. A certificate shall be attached to the petition which includes a statement from the person's physician or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment.~~

~~4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide~~

~~copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.~~

~~(b) Within 1 court working day after the filing of a petition for continued involuntary outpatient services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed or the court order expires or the patient is discharged from involuntary outpatient services. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(c) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the order for involuntary outpatient services. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7), except that the time period included in paragraph (2)(c) is not applicable in determining the appropriateness of additional periods of involuntary~~

~~outpatient placement.~~

~~(d) Notice of the hearing must be provided as set forth in s. 394.4599. The patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.~~

~~(e) The same procedure must be repeated before the expiration of each additional period the patient is placed in treatment.~~

~~(f) If the patient has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. Section 394.4598 governs the discharge of the guardian advocate if the patient's competency to consent to treatment has been restored.~~

Section 12. Section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary services ~~inpatient placement~~.—

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

(a) "Court" means a circuit court.

(b) "Involuntary inpatient placement" means services provided on an inpatient basis to a person 18 years of age or older who does not voluntarily consent to services under this chapter, or a minor who does not voluntarily assent to services under this chapter.

(c) "Involuntary outpatient services" means services provided on an outpatient basis to a person who does not

voluntarily consent to services under this chapter.

(2)~~(1)~~ CRITERIA FOR INVOLUNTARY SERVICES.—A person may be ordered by a court to be provided ~~for~~ involuntary services ~~inpatient placement for treatment~~ upon a finding of the court, by clear and convincing evidence, that the person meets the following criteria:

(a) The person ~~He or she~~ has a mental illness and because of his or her mental illness:

1.a. Is unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services or ~~He or she has refused~~ voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of ~~inpatient placement for~~ treatment; or

b. ~~He or she~~ Is unable to determine for himself or herself whether services or inpatient placement is necessary; and

2.a. Is unlikely to survive safely in the community without supervision, based on clinical determination;

b.~~2.a. He or she~~ Is incapable of surviving alone or with the help of willing, able, and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

c.~~b.~~ Without treatment, there is a substantial likelihood that in the near future the person ~~he or she~~ will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting to cause, or threatening to cause such harm.~~; and~~

(b) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services to prevent a relapse or deterioration of his or her mental health that would be likely to result in serious bodily harm to self or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).

(c) The person has a history of lack of compliance with treatment for mental illness.

(d) It is likely that the person will benefit from involuntary services.

(e)~~(b)~~ All available less restrictive treatment alternatives that would offer an opportunity for improvement of the person's ~~his or her~~ condition have been deemed ~~judged~~ to be inappropriate or unavailable.

(3)~~(2)~~ RECOMMENDATION FOR INVOLUNTARY SERVICES AND ~~ADMISSION TO A~~ TREATMENT ~~FACILITY~~.—A patient may be recommended for involuntary inpatient placement, involuntary outpatient services, or a combination of both.

(a) A patient may be retained by a facility for involuntary services ~~or involuntarily placed in a treatment~~

~~facility~~ upon the recommendation of the administrator of the facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. However, if a patient who is being recommended for only involuntary outpatient services has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services.

(b) The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary services ~~inpatient placement~~ are met.

(c) If ~~However, if the administrator certifies that~~ a psychiatrist or clinical psychologist is not available to provide a ~~the~~ second opinion, the administrator must certify that a clinical psychologist is not available and the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse. If the patient is being recommended for involuntary outpatient services only, the second opinion may be provided by a physician assistant who has at least 3 years' experience and is supervised by a licensed physician or psychiatrist or a clinical social worker.

(d) Any opinion authorized in this subsection may be

conducted through a face-to-face or in-person examination, ~~in person,~~ or by electronic means. Recommendations for involuntary services must be ~~Such recommendation shall be~~ entered on an ~~a petition for~~ involuntary services ~~inpatient placement~~ certificate, which shall be made a part of the patient's clinical record. The certificate must either authorize the facility to retain the patient pending completion of a hearing or authorize ~~that authorizes~~ the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

(4)~~(3)~~ PETITION FOR INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a) A petition for involuntary services may be filed by:

1. The administrator of a receiving ~~the~~ facility; or

2. The administrator of a treatment facility.

(b) A ~~shall file a~~ petition for involuntary inpatient placement, or inpatient placement followed by outpatient services, must be filed in the court in the county where the patient is located.

(c) A petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside.

(d)1. The petitioner must state in the petition:

a. Whether the petitioner is recommending inpatient placement, outpatient services, or both.

b. The length of time recommended for each type of involuntary services.

c. The reasons for the recommendation.

2. If recommending involuntary outpatient services, or a combination of involuntary inpatient placement and outpatient services, the petitioner must identify the service provider that will have primary responsibility for providing such services under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. If recommending an immediate order to involuntary outpatient placement, the service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for

terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested service.

(e) Each required criterion for the recommended involuntary services must be alleged and substantiated in the petition. A copy of the certificate recommending involuntary services completed by a qualified professional specified in subsection (3) and, if applicable, a copy of the proposed treatment plan must be attached to the petition.

(f) When the petition has been filed ~~Upon filing~~, the clerk of the court shall provide copies of the petition and, if applicable, the proposed treatment plan to the department, the

managing entity, the patient, the patient's guardian or representative, ~~and~~ the state attorney, and the public defender or the patient's private counsel ~~of the judicial circuit in which the patient is located~~. A fee may not be charged for the filing of a petition under this subsection.

(5)~~(4)~~ APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary services ~~inpatient placement~~, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel or ineligible. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary services. Any attorney who represents ~~representing~~ the patient shall be provided ~~have~~ access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(6)~~(5)~~ CONTINUANCE OF HEARING.—The patient and the state are independently ~~is~~ entitled~~, with the concurrence of the patient's counsel,~~ to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires the concurrence of the patient's counsel. The state's continuance may be for a period of up to 5 court working

days and requires a showing of good cause and due diligence by the state before requesting the continuance. The state's failure to timely review any readily available document or failure to attempt to contact a known witness does not warrant a continuance.

(7)~~(6)~~ HEARING ON INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a)1. The court shall hold a ~~the~~ hearing on the involuntary services petition ~~inpatient placement~~ within 5 court working days after the filing of the petition, unless a continuance is granted.

2. The court must hold any hearing on involuntary outpatient services in the county where the petition is filed. A hearing on involuntary inpatient placement, or a combination of involuntary inpatient placement and involuntary outpatient services, ~~Except for good cause documented in the court file, the hearing~~ must be held in the county or the facility, as appropriate, where the patient is located, except for good cause documented in the court file.

3. A hearing on involuntary services must be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient, or the patient knowingly,

intelligently, and voluntarily waives his or her right to be present, and if the patient's counsel does not object, the court may waive the attendance ~~presence~~ of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding. The facility shall make the respondent's clinical records available to the state attorney and the respondent's attorney so that the state can evaluate and prepare its case. However, these records shall remain confidential, and the state attorney may not use any record obtained under this part for criminal investigation or prosecution purposes, or for any purpose other than the patient's civil commitment under this chapter ~~petitioning facility administrator, as the real party in interest in the proceeding~~.

(b)~~3.~~ The court may appoint a magistrate to preside at the hearing on the petition and any ancillary proceedings, including, but not limited to, writs of habeas corpus issued pursuant to s. 394.459. Upon a finding of good cause, the court may permit all witnesses, including, but not limited to, medical professionals who are or have been involved with the patient's treatment, to remotely attend and testify at the hearing under oath via audio-video teleconference. A witness intending to remotely attend and testify must provide the parties with all relevant documents by the close of business on the day before

the hearing. One of the professionals who executed the ~~petition for~~ involuntary services ~~inpatient placement~~ certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided for by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from persons, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

(c) ~~(b)~~ At the hearing, the court shall consider testimony and evidence regarding the patient's competence to consent to services and treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598.

(8) ORDERS OF THE COURT.—

(a)1. If the court concludes that the patient meets the criteria for involuntary services, the court may order a patient to involuntary inpatient placement, involuntary outpatient

services, or a combination of involuntary services depending on the criteria met and which type of involuntary services best meet the needs of the patient. However, if the court orders the patient to involuntary outpatient services, the court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court.

2. The order must specify the nature and extent of the patient's mental illness.

3.a. An order for only involuntary outpatient services shall be for a period of up to 90 days.

b. An order for involuntary inpatient placement, or a combination of inpatient placement and outpatient services, may be up to 6 months.

4. An order for a combination of involuntary services shall specify the length of time the patient shall be ordered for involuntary inpatient placement and involuntary outpatient services.

5. The order of the court and the patient's treatment plan, if applicable, must be made part of the patient's clinical record.

(b) If the court orders a patient into involuntary inpatient placement, the court ~~it~~ may order that the patient be transferred to a treatment facility, or~~,~~ if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate facility, or that the patient receive services~~,~~ on an involuntary basis~~, for up to 90 days~~. ~~However, any order for involuntary mental health services in a treatment facility may be for up to 6 months. The order shall specify the nature and extent of the patient's mental illness.~~ The court may not order an individual with a developmental disability as defined in s. 393.063 or a traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility. ~~The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.~~

(c) If at any time before the conclusion of a ~~the~~ hearing on involuntary services, ~~inpatient placement~~ it appears to the court that the patient ~~person does not meet the criteria for involuntary inpatient placement under this section, but~~ instead meets the criteria for involuntary ~~outpatient services, the court may order the person evaluated for involuntary outpatient~~

~~services pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary~~ admission or treatment pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment ~~for a period of 5 days~~ pursuant to s. 397.6757 ~~s. 397.6811~~. Thereafter, all proceedings are governed by chapter 397.

~~(d) At the hearing on involuntary inpatient placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598.~~

(d) ~~(e)~~ The administrator of the petitioning facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient services or the administrator of a treatment facility if the patient is ordered for involuntary inpatient placement~~, whether by civil or criminal court~~. The documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychiatric nurse, a clinical psychologist, a marriage and family therapist, a mental health counselor, or a clinical social worker. The administrator of a treatment facility may

refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or criminal court order, who is not accompanied by adequate orders and documentation.

(9) TREATMENT PLAN MODIFICATION—After the order for involuntary outpatient services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (4).

(10) NONCOMPLIANCE WITH INVOLUNTARY OUTPATIENT SERVICES.—If, in the clinical judgment of a physician, a patient receiving involuntary outpatient services has failed or has refused to comply with the treatment plan ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement under this section, the patient must be discharged from the facility. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no

longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (4).

(11) ~~(7)~~ PROCEDURE FOR CONTINUED INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a) A petition for continued involuntary services shall be filed if the patient continues to meets the criteria for involuntary services.

(b)1. If a patient receiving involuntary outpatient services continues to meet the criteria for involuntary outpatient services, the service provider shall file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services.

2. If the patient in involuntary inpatient placement

~~(a) Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in~~

~~accordance with s. 120.57(1), except that any order entered by the administrative law judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity are governed by s. 916.15.~~

~~(b) If the patient~~ continues to meet the criteria for involuntary inpatient placement and is being treated at a treatment facility, the administrator shall, before the expiration of the period the treatment facility is authorized to retain the patient, file a petition requesting authorization for continued involuntary inpatient placement.

3. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.

4. The existing involuntary services order shall remain in effect until disposition on the petition for continued involuntary services.

(c) A certificate for continued involuntary services must be attached to the petition and shall include ~~The request must be accompanied by~~ a statement from the patient's physician, psychiatrist, psychiatric nurse, or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services ~~involuntarily placed~~, and, if requesting involuntary outpatient services, an individualized plan of continued treatment. The individualized plan of continued treatment shall

be developed in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.

(d) The court shall appoint counsel to represent the person who is the subject of the petition for continued involuntary services in accordance to the provisions set forth in subsection (5), unless the person is otherwise represented by counsel or ineligible.

(e) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the order for involuntary outpatient services. However, the patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.

(f) Hearings on petitions for continued involuntary inpatient placement must be held in the county or the facility, as appropriate, where the patient is located.

(g) The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7).

(h) Notice of the hearing must be provided as set forth ~~provided~~ in s. 394.4599.

(i) If a patient's attendance at the hearing is voluntarily waived, the ~~administrative law~~ judge must determine that the patient knowingly, intelligently, and voluntarily waived his or her right to be present, ~~waiver is knowing and voluntary~~ before waiving the presence of the patient from all or a portion of the hearing. Alternatively, if at the hearing the ~~administrative law~~ judge finds that attendance at the hearing is not consistent with the best interests of the patient, the ~~administrative law~~ judge may waive the presence of the patient from all or any portion of the hearing, unless the patient, through counsel, objects to the waiver of presence. The testimony in the hearing must be under oath~~,~~ and the proceedings must be recorded.

(j) Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in accordance with s. 120.57(1), except that any order entered by the judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity are governed by s. 916.15.

~~(c) Unless the patient is otherwise represented or is ineligible, he or she shall be represented at the hearing on the petition for continued involuntary inpatient placement by the public defender of the circuit in which the facility is located.~~

(k) ~~(d)~~ If at a hearing it is shown that the patient continues to meet the criteria for involuntary services ~~inpatient placement~~, the court ~~administrative law judge~~ shall issue an ~~sign the~~ order for continued involuntary services ~~inpatient placement~~ for up to 90 days. However, any order for involuntary inpatient placement, or ~~mental health services in~~ a combination of involuntary services ~~treatment facility~~ may be for up to 6 months. The same procedure shall be repeated before the expiration of each additional period the patient is retained.

(l) If the patient has been ordered to undergo involuntary services and has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. If the patient's competency to consent to treatment is restored, the discharge of the guardian advocate shall be governed by s. 394.4598. If the patient has been ordered to undergo involuntary inpatient placement only and the patient's competency to consent to treatment is restored, the administrative law judge may issue a recommended order, to the court that found the patient incompetent to consent to treatment, that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

(m) ~~(e)~~ If continued involuntary inpatient placement is necessary for a patient in involuntary inpatient placement who

was admitted while serving a criminal sentence, but his or her sentence is about to expire, or for a minor involuntarily placed, but who is about to reach the age of 18, the administrator shall petition the administrative law judge for an order authorizing continued involuntary inpatient placement. The procedure required in this section ~~subsection~~ must be followed before the expiration of each additional period the patient is involuntarily receiving services.

(12) ~~(8)~~ RETURN TO FACILITY.—If a patient has been ordered to undergo involuntary inpatient placement ~~involuntarily~~ held at a treatment facility under this part leaves the facility without the administrator's authorization, the administrator may authorize a search for the patient and his or her return to the facility. The administrator may request the assistance of a law enforcement agency in this regard.

(13) DISCHARGE—The patient shall be discharged upon expiration of the court order or at any time the patient no longer meets the criteria for involuntary services, unless the patient has transferred to voluntary status. Upon discharge, the service provider or facility shall send a certificate of discharge to the court.

Section 13. Subsection (2) of section 394.468, Florida Statutes, is amended and subsection (3) is added to that section to read:

394.468 Admission and discharge procedures.—

(2) Discharge planning and procedures for any patient's release from a receiving facility or treatment facility must include and document the patient's needs, and actions to address such needs, for ~~consideration of~~, at a minimum:

(a) Follow-up behavioral health appointments;

(b) Information on how to obtain prescribed medications; and

(c) Information pertaining to:

1. Available living arrangements;

2. Transportation; and

(d) Referral to:

1. Care coordination services. The patient must be referred for care coordination services if the patient meets the criteria as a member of a priority population as determined by the department under s. 394.9082(3)(c) and is in need of such services.

2.~~3.~~ Recovery support opportunities under s. 394.4573(2)(l), including, but not limited to, connection to a peer specialist.

(3) During the discharge transition process and while the patient is present unless determined inappropriate by a licensed medical practitioner, a receiving facility shall coordinate, face-to-face or through electronic means, discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service. The

transition process must include all of the following criteria:

(a) Implementation of policies and procedures outlining strategies for how the receiving facility will comprehensively address the needs of patients who demonstrate a high use of receiving facility services to avoid or reduce future use of crisis stabilization services.

(b) Developing and including in discharge paperwork a personalized crisis prevention plan that identifies stressors, early warning signs or symptoms, and strategies to deal with crisis.

(c) Requiring a staff member to seek to engage a family member, legal guardian, legal representative, or natural support in discharge planning and meet face to face or through electronic means to review the discharge instructions, including prescribed medications, follow-up appointments, and any other recommended services or follow-up resources, and document the outcome of such meeting.

(d) When the recommended level of care at discharge is not immediately available to the patient, the receiving facility must, at a minimum, initiate a referral to an appropriate provider to meet the needs of the patient to continue care until the recommended level of care is available.

Section 14. Subsection (3) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care;

programs and services.—

(3) Assessments must be performed by:

(a) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~;

(b) A professional licensed under chapter 491; or

(c) A person who is under the direct supervision of a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455, ~~qualified professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491.

Section 15. Subsection (5) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(5) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455, ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 16. Paragraph (a) of subsection (2) of section 394.499, Florida Statutes, is amended to read:

394.499 Integrated children's crisis stabilization

unit/juvenile addictions receiving facility services.—

(2) Children eligible to receive integrated children's crisis stabilization unit/juvenile addictions receiving facility services include:

(a) A minor whose parent makes ~~person under 18 years of age for whom~~ voluntary application based on the parent's express and informed consent, and the requirements of s. 394.4625(1)(a) are met ~~is made by his or her guardian, if such person is found to show evidence of mental illness and to be suitable for treatment pursuant to s. 394.4625. A person under 18 years of age may be admitted for integrated facility services only after a hearing to verify that the consent to admission is voluntary~~.

Section 17. Paragraphs (a) and (d) of subsection (1) of section 394.875, Florida Statutes, are amended to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a licensed medical practitioner

~~physician~~ or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay ~~and shall be limited in size to a maximum of 30 beds~~.

~~(d) The department is directed to implement a demonstration project in circuit 18 to test the impact of expanding beds authorized in crisis stabilization units from 30 to 50 beds. Specifically, the department is directed to authorize existing public or private crisis stabilization units in circuit 18 to expand bed capacity to a maximum of 50 beds and to assess the impact such expansion would have on the availability of crisis stabilization services to clients.~~

Section 18. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification ~~services~~," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(26)(a)4. ~~397.311(26)(a)3.~~, 397.311(26)(a)1., and 394.455(41) ~~394.455(40)~~, respectively.

Section 19. Subsection (3) of section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(3) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance

abuse prevention, intervention, clinical treatment, and recovery support services in the most appropriate and least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

Section 20. Subsections (19) and (23) of section 397.311, Florida Statutes, are amended to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(19) "Impaired" or "substance abuse impaired" means having a substance use disorder or a condition involving the use of alcoholic beverages, illicit or prescription drugs, or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems or ~~and~~ cause socially dysfunctional behavior.

(23) "Involuntary treatment services" means an array of behavioral health services that may be ordered by the court for persons with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders.

Section 21. Subsection (6) is added to section 397.401, Florida Statutes, to read:

397.401 License required; penalty; injunction; rules waivers.—

(6) A service provider operating an addictions receiving facility or providing detoxification on a nonhospital inpatient basis may not exceed its licensed capacity by more than 10 percent and may not exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

Section 22. Paragraph (i) is added to subsection (1) of section 397.4073, Florida Statutes, to read:

397.4073 Background checks of service provider personnel.—

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.—

(i) Any licensed physician or nurse who requires background screening by the Department of Health during initial licensure and the renewal of licensure is not subject to background screening pursuant to this section if he or she is providing a service that is within the scope of his or her licensed practice.

Section 23. Subsection (8) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(8) RIGHT TO COUNSEL.—Each individual must be informed that he or she has the right to be represented by counsel in any

judicial ~~involuntary~~ proceeding for involuntary substance abuse ~~assessment, stabilization, or~~ treatment and that he or she, or if the individual is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

Section 24. Section 397.581, Florida Statutes, is amended to read:

397.581 Unlawful activities relating to assessment and treatment; penalties.—

(1) A person may not knowingly and willfully:

(a) Furnish ~~furnishing~~ false information for the purpose of obtaining emergency or other involuntary admission of another person ~~for any person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000~~.

(b) ~~(2)~~ Cause or otherwise secure, or conspire with or assist another to cause or secure ~~Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired,~~ any emergency or other involuntary procedure of another ~~for the~~ person under false pretenses ~~is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000~~.

(c) ~~(3)~~ Cause, or conspire with or assist another to cause, without lawful justification ~~Causing, or conspiring with or~~

~~assisting another to cause~~, the denial to any person of any right accorded pursuant to this chapter.

(2) A person who violates subsection (1) commits ~~is~~ a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Section 25. Section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe that the person is substance abuse impaired or has a substance use disorder and a co-occurring mental health disorder and, because of such impairment or disorder:

(1) Has lost the power of self-control with respect to substance abuse; and

(2)(a) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard, although mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services; or

(b) Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services, or there is substantial likelihood that the person has inflicted, or threatened to or attempted to inflict, or, unless admitted, is likely to inflict, physical harm on himself, herself, or another.

Section 26. Subsection (1) of section 397.6751, Florida Statutes, is amended to read:

397.6751 Service provider responsibilities regarding involuntary admissions.—

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the most appropriate and least restrictive available setting that is responsive to the person's treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

Section 27. Section 397.681, Florida Statutes, is amended to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.—

(1) JURISDICTION.—The courts have jurisdiction of ~~involuntary assessment and stabilization petitions and~~ involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person resides ~~is located~~. The clerk of the court may not charge a fee for the filing of a petition under this section. The chief judge may appoint a general or special magistrate to preside over all or part of the proceedings related to the petition or any ancillary matters

thereto. The alleged impaired person is named as the respondent.

(2) RIGHT TO COUNSEL.—Unless the respondent is present and the court finds he or she knowingly, intelligently, and voluntarily waived legal representation, a respondent has the right to counsel at every stage of a judicial proceeding relating to a petition for his or her ~~involuntary assessment and a petition for his or her~~ involuntary treatment for substance abuse impairment. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs or desires the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

Section 28. Section 397.693, Florida Statutes, is renumbered as 397.68111, Florida Statutes, and amended to read:

397.68111 ~~397.693~~ Involuntary treatment.—A person may be the subject of a petition for court-ordered involuntary treatment pursuant to this part~~,~~ if that person:

(1) Reasonably appears to meet ~~meets~~ the criteria for involuntary admission provided in s. 397.675; ~~and:~~

(2)~~(1)~~ Has been placed under protective custody pursuant to s. 397.677 within the previous 10 days;

(3)~~(2)~~ Has been subject to an emergency admission pursuant to s. 397.679 within the previous 10 days; or

(4)~~(3)~~ Has been assessed by a qualified professional within 30 ~~5~~ days~~;~~

~~(4) Has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days; or~~

~~(5) Has been subject to alternative involuntary admission pursuant to s. 397.6822 within the previous 12 days~~.

Section 29. Section 397.695, Florida Statutes, is renumbered as section 397.68112, Florida Statutes, and amended to read:

397.68112 ~~397.695~~ Involuntary services; persons who may petition.—

(1) If the respondent is an adult, a petition for involuntary treatment services may be filed by the respondent's spouse or legal guardian, any relative, a service provider, or an adult who has direct personal knowledge of the respondent's substance abuse impairment and his or her prior course of assessment and treatment.

(2) If the respondent is a minor, a petition for involuntary treatment services may be filed by a parent, legal guardian, or service provider.

(3) The court may prohibit, or a law enforcement agency may waive, any service of process fees if a petitioner is

determined to be indigent.

Section 30. Section 397.6951, Florida Statutes, is renumbered as 397.68141, Florida Statutes, and amended to read:

397.68141 ~~397.6951~~ Contents of petition for involuntary treatment services.—A petition for involuntary services must contain the name of the respondent; the name of the petitioner ~~or petitioners~~; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known; ~~the findings and recommendations of the assessment performed by the qualified professional;~~ and the factual allegations presented by the petitioner establishing the need for involuntary ~~outpatient~~ services for substance abuse impairment. The factual allegations must demonstrate:

(1) The reason for the petitioner's belief that the respondent is substance abuse impaired;

(2) The reason for the petitioner's belief that because of such impairment the respondent has lost the power of self-control with respect to substance abuse; and

(3)(a) The reason the petitioner believes that the respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless the court orders the involuntary services; or

(b) The reason the petitioner believes that the respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the

respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

(4) The petition may be accompanied by a certificate or report of a qualified professional who examined the respondent within 30 days before the petition was filed. The certificate or report must include the qualified professional's findings relating to his or her assessment of the patient and his or her treatment recommendations. If the respondent was not assessed before the filing of a treatment petition or refused to submit to an evaluation, the lack of assessment or refusal must be noted in the petition.

(5) If there is an emergency, the petition must also describe the respondent's exigent circumstances and include a request for an ex parte assessment and stabilization order that must be executed pursuant to s. 397.68151.

Section 31. Section 397.6955, Florida Statutes, is renumbered as section 397.68151, Florida Statutes, and amended to read:

397.68151 ~~397.6955~~ Duties of court upon filing of petition for involuntary services.—

(1) Upon the filing of a petition for involuntary services for a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. If the

court appoints counsel for the person, the clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel, created pursuant to s. 27.511, of the appointment. The office of criminal conflict and civil regional counsel shall represent the person until the petition is dismissed, the court order expires, ~~or~~ the person is discharged from involuntary treatment services, or the office is otherwise discharged by the court. An attorney that represents the person named in the petition shall have access to the person, witnesses, and records relevant to the presentation of the person's case and shall represent the interests of the person, regardless of the source of payment to the attorney.

(2) The court shall schedule a hearing to be held on the petition within 10 court working ~~5~~ days unless a continuance is granted. ~~The court may appoint a magistrate to preside at the hearing.~~

(3) A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct. If the respondent is a minor, a copy of the petition and notice of the hearing must be personally delivered to the respondent. The clerk ~~court~~ shall also issue a summons to the person whose admission is sought and

unless a circuit court's chief judge authorizes disinterested private process servers to serve parties under this chapter, a law enforcement agency must effect such service on the person whose admission is sought for the initial treatment hearing.

Section 32. Section 397.6818, Florida Statutes, is amended to read:

397.6818 Court determination.—

(1) When the petitioner asserts that emergency circumstances exist, or when upon review of the petition the court determines that an emergency exists, the court may rely solely on the contents of the petition and, without the appointment of an attorney, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending.

(2) The court may further order a law enforcement officer or another designated agent of the court to:

(a) Take the respondent into custody and deliver him or her for evaluation to either the nearest appropriate licensed service provider or a licensed service provider designated by the court.

(b) Serve the respondent with the notice of hearing and a copy of the petition.

(3) The service provider may not hold the respondent for longer than 72 hours of observation, unless:

(a) The service provider seeks additional time under s. 397.6957(1)(c) and the court, after a hearing, grants that motion;

(b) The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until the issue is resolved but no later than the scheduled hearing date, absent a court-approved extension; or

(c) The original or extended observation period ends on a weekend or holiday, including the hours before the ordinary business hours of the following workday morning, in which case the provider may hold the respondent until the next court working day.

(4) If the ex parte order was not executed by the initial hearing date, it shall be deemed void. However, should the respondent not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets this chapter's commitment criteria and that a substance abuse emergency exists, the court may issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:

(a) Shall continue the case for no more than 10 court working days; and

(b) May order a law enforcement officer or another designated agent of the court to:

1. Take the respondent into custody and deliver him or her for evaluation to either the nearest appropriate licensed service provider or a licensed service provider designated by the court; and

2. If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

Otherwise, the petitioner must inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as is practicable. However, if the respondent has not been assessed within 90 days, the court must dismiss the case. ~~At the hearing initiated in accordance with s. 397.6811(1), the court shall hear all relevant testimony. The respondent must be present unless the court has reason to believe that his or her presence is likely to be injurious to him or her, in which event the court shall appoint a guardian advocate to represent the respondent. The respondent has the right to examination by a court-appointed qualified professional. After hearing all the evidence, the court shall determine whether there is a reasonable basis to believe the respondent meets the involuntary admission criteria of s.~~

~~397.675.~~

~~(1) Based on its determination, the court shall either dismiss the petition or immediately enter an order authorizing the involuntary assessment and stabilization of the respondent; or, if in the course of the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to injure himself or herself or another if allowed to remain at liberty, the court may initiate involuntary proceedings under the provisions of part I of chapter 394.~~

~~(2) If the court enters an order authorizing involuntary assessment and stabilization, the order shall include the court's findings with respect to the availability and appropriateness of the least restrictive alternatives and the need for the appointment of an attorney to represent the respondent, and may designate the specific licensed service provider to perform the involuntary assessment and stabilization of the respondent. The respondent may choose the licensed service provider to deliver the involuntary assessment where possible and appropriate.~~

~~(3) If the court finds it necessary, it may order the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order or, if none is specified, to the nearest appropriate licensed service provider for involuntary assessment.~~

~~(4) The order is valid only for the period specified in the order or, if a period is not specified, for 7 days after the order is signed.~~

Section 33. Section 397.6957, Florida Statutes, is amended to read:

397.6957 Hearing on petition for involuntary treatment services.—

(1)(a) The respondent must be present at a hearing on a petition for involuntary treatment services~~,~~ unless the court finds that he or she knowingly, intelligently, and voluntarily waives his or her right to be present or, upon receiving proof of service and evaluating the circumstances of the case, that his or her presence is inconsistent with his or her best interests or is likely to be injurious to self or others. The court shall hear and review all relevant evidence, including testimony from individuals such as family members familiar with the respondent's prior history and how it relates to his or her current condition, and the ~~review of~~ results of the assessment completed by the qualified professional in connection with this chapter. The court may also order drug tests. Upon a finding of good cause, the court may permit all witnesses, including, but not limited to, medical professionals who are or have been involved with the respondent's treatment, to remotely attend and testify at the hearing under oath via audio-video teleconference. A witness intending to remotely attend and

testify must provide the parties with all relevant documents by the close of business on the day before the hearing ~~the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others, in which event the court must appoint a guardian advocate to act in behalf of the respondent throughout the proceedings~~.

(b) A respondent may not be involuntarily ordered into treatment under this chapter without a clinical assessment being performed, unless he or she is present in court and expressly waives the assessment. In nonemergency situations, if the respondent was not, or had previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it reasonably appears that the respondent qualifies for involuntary treatment services, the court shall issue an involuntary assessment and stabilization order to determine the appropriate level of treatment the respondent requires. Additionally, in cases where an assessment was attached to the petition, the respondent may request, or the court on its own motion may order, an independent assessment by a court-appointed or otherwise agreed upon qualified professional. If an assessment order is issued, it is valid for 90 days, and if the respondent is present or there is either

proof of service or his or her location is known, the involuntary treatment hearing shall be continued for no more than 10 court working days. Otherwise, the petitioner must inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as is practicable. The assessment must occur before the new hearing date, and if there is evidence indicating that the respondent will not voluntarily appear at the forthcoming hearing or is a danger to self or others, the court may enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the date of the rescheduled hearing. However, if after 90 days the respondent remains unassessed, the court shall dismiss the case.

(c)1. The respondent's assessment by a qualified professional must occur within 72 hours after his or her arrival at a licensed service provider unless the respondent shows signs of withdrawal or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until such issue is resolved but no later than the scheduled hearing date, absent a court-approved extension. If the respondent is a minor, such assessment must be initiated within the first 12 hours of the minor's admission to the facility. The service provider may also move to extend the 72 hours of observation by petitioning the court in writing for additional time. The service provider must

furnish copies of such motion to all parties in accordance with applicable confidentiality requirements, and after a hearing, the court may grant additional time. If the court grants the service provider's petition, the service provider may continue to hold the respondent, and if the original or extended observation period ends on a weekend or holiday, including the hours before the ordinary business hours of the following workday morning, the provider may hold the respondent until the next court working day.

2. No later than the ordinary close of business on the day before the hearing, the qualified professional shall transmit, in accordance with any applicable confidentiality requirements, his or her clinical assessment to the clerk of the court, who shall enter it into the court file. The report must contain a recommendation on the level of substance abuse treatment the respondent requires, if any, and the relevant information on which the qualified professional's findings are based. This document must further note whether the respondent has any co-occurring mental health or other treatment needs. For adults subject to an involuntary assessment, the report's filing with the court satisfies s. 397.6758 if it also contains the respondent's admission and discharge information. The qualified professional's failure to include a treatment recommendation, much like a recommendation of no treatment, shall result in the petition's dismissal.

(2) The petitioner has the burden of proving by clear and convincing evidence that:

(a) The respondent is substance abuse impaired and has a history of lack of compliance with treatment for substance abuse; and

(b) Because of such impairment the respondent is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:

1. Without services, the respondent is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that there is a substantial likelihood that without services the respondent will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or

2. The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

(3) ~~One of the qualified professionals who executed the involuntary services certificate must be a witness. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law,~~

~~regarding the respondent's prior history and how that prior history relates to the person's current condition. The~~ Testimony in the hearing must be taken under oath, and the proceedings must be recorded. The respondent ~~patient~~ may refuse to testify at the hearing.

(4) If at any point during the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, meets the involuntary commitment provisions of part I of chapter 394, the court may initiate involuntary examination proceedings under such provisions.

(5)~~(4)~~ At the conclusion of the hearing the court shall either dismiss the petition or order the respondent to receive involuntary treatment services from his or her chosen licensed service provider if possible and appropriate. Any treatment order must include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Section 34. Section 397.6975, Florida Statutes, is amended to read:

397.6975 Extension of involuntary treatment services period.—

(1) Whenever a service provider believes that an individual who is nearing the scheduled date of his or her release from involuntary treatment services continues to meet

the criteria for involuntary services in s. 397.68111 or s. 397.6957 ~~s. 397.693~~, a petition for renewal of the involuntary treatment services order may be filed with the court at least 10 days before the expiration of the court-ordered services period. The petition may be filed by the service provider or by the person who filed the petition for the initial treatment order if the petition is accompanied by supporting documentation from the service provider. The court shall immediately schedule a hearing within 10 court working days to be held not more than 15 days after filing of the petition and~~.~~ the court shall provide the copy of the petition for renewal and the notice of the hearing to all parties and counsel to the proceeding. The hearing is conducted pursuant to ss. 397.6957 and 397.697 and must be held before the circuit court unless referred to a magistrate ~~s. 397.6957~~.

(2) If the court finds that the petition for renewal of the involuntary treatment services order should be granted, it may order the respondent to receive involuntary treatment services for a period not to exceed an additional 90 days. When the conditions justifying involuntary treatment services no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary services continue to exist after an additional 90 days of service, a new petition requesting renewal of the involuntary treatment services order may be filed pursuant to this section.

~~(3) Within 1 court working day after the filing of a petition for continued involuntary services, the court shall appoint the office of criminal conflict and civil regional counsel to represent the respondent, unless the respondent is otherwise represented by counsel. The clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel of such appointment. The office of criminal conflict and civil regional counsel shall represent the respondent until the petition is dismissed or the court order expires or the respondent is discharged from involuntary services. Any attorney representing the respondent shall have access to the respondent, witnesses, and records relevant to the presentation of the respondent's case and shall represent the interests of the respondent, regardless of the source of payment to the attorney.~~

~~(4) Hearings on petitions for continued involuntary services shall be before the circuit court. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this section shall be in accordance with s. 397.697.~~

~~(5) Notice of hearing shall be provided to the respondent or his or her counsel. The respondent and the respondent's counsel may agree to a period of continued involuntary services without a court hearing.~~

~~(6) The same procedure shall be repeated before the~~

~~expiration of each additional period of involuntary services.~~

~~(7) If the respondent has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the respondent's competence.~~

Section 35. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary services.—

(1) At the conclusion of the 90-day period of court-ordered involuntary services, the respondent is automatically discharged unless a motion for renewal of the involuntary services order has been filed with the court pursuant to s. 397.6975.

(2) Discharge planning and procedures for any respondent's release from involuntary treatment services must include and document the respondent's needs, and actions to address such needs, for, at a minimum:

(a) Follow-up behavioral health appointments.

(b) Information on how to obtain prescribed medications.

(c) Information pertaining to available living arrangements and transportation.

(d) Referral to recovery support opportunities, including, but not limited to, connection to a peer specialist.

Section 36. Section 397.6811, Florida Statutes, is repealed.

Section 37. Section 397.6814, Florida Statutes, is repealed.

Section 38. Section 397.6815, Florida Statutes, is repealed.

Section 39. Section 397.6819, Florida Statutes, is repealed.

Section 40. Section 397.6821, Florida Statutes, is repealed.

Section 41. Section 397.6822, Florida Statutes, is repealed.

Section 42. Section 397.6978, Florida Statutes, is repealed.

Section 43. Subsections (14) through (17) of section 916.106, Florida Statutes, are renumbered as subsections (15) through (18), respectively, and a new subsection (14) is added to that section, to read:

916.106 Definitions.—For the purposes of this chapter, the term:

(14) "Licensed medical practitioner" means a medical provider who is a physician licensed under chapter 458 or chapter 459 or an advanced practice registered nurse or physician assistant who works under the supervision of a licensed physician and an established protocol pursuant to ss. 458.347, 458.348, 464.003, and 464.0123.

Section 44. Section (2) of section 916.13, Florida

Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment under this chapter, may be committed to the department, and the department shall retain and treat the defendant.

(a) Immediately after receipt of a completed copy of the court commitment order containing all documentation required by the applicable Florida Rules of Criminal Procedure, the department shall request all medical information relating to the defendant from the jail. The jail shall provide the department with all medical information relating to the defendant within 3 business days after receipt of the department's request or at the time the defendant enters the physical custody of the department, whichever is earlier.

(b) Within 60 days after the date of admission and at the end of any period of extended commitment, or at any time the administrator or his or her designee determines that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

(c)1. If the department determines at any time that a

defendant will not or is unlikely to regain competency to proceed, the department shall, within 30 days after the determination, complete and submit a competency evaluation report to the circuit court to determine if the defendant meets the criteria for involuntary civil commitment under s. 394.467. A qualified professional, as defined in s. 394.455, must sign the competency evaluation report for the circuit court under penalty of perjury. A copy of the report shall be provided, at a minimum, to the court, state attorney, and counsel for the defendant before initiating any transfer of the defendant back to the committing jurisdiction.

2. For purposes of this paragraph, the term "competency evaluation report to the circuit court" means a report by the department regarding a defendant's incompetence to proceed in a criminal proceeding due to mental illness as set forth in this section. The report shall include, at a minimum, the following regarding the defendant:

a. A description of mental, emotional, and behavioral disturbances.

b. An explanation to support the opinion of incompetence to proceed.

c. The rationale to support why the defendant is unlikely to gain competence to proceed in the foreseeable future.

d. A clinical opinion regarding whether the defendant no longer meets the criteria for involuntary forensic commitment

pursuant to this section.

e. A recommendation on whether the defendant meets the criteria for involuntary services pursuant to s. 394.467.

(d) ~~(c)~~ The defendant must be transported, in accordance with s. 916.107, to the committing court's jurisdiction within 7 days after ~~of~~ notification that the defendant is competent to proceed or no longer meets the criteria for continued commitment. A determination on the issue of competency must be made at a hearing within 30 days of the notification. If the defendant is receiving psychotropic medication at a mental health facility at the time he or she is discharged and transferred to the jail, the administering of such medication must continue unless the jail physician documents the need to change or discontinue it. To ensure continuity of care, the referring mental health facility must transfer the patient with up to 30 days of medications and assist in discharge planning with medical teams at the receiving county jail. The jail and facility's licensed medical practitioners ~~department physicians~~ shall collaborate to ensure that medication changes do not adversely affect the defendant's mental health status or his or her ability to continue with court proceedings; however, the final authority regarding the administering of medication to an inmate in jail rests with the jail physician. Notwithstanding this paragraph, a defendant who meets the criteria for involuntary examination pursuant to s. 394.463 as determined by

an independent clinical opinion shall appear remotely for the hearing. Court witnesses may appear remotely.

Section 45. Subsection (6) of section 40.29, Florida Statutes, is amended to read:

40.29 Payment of due-process costs; reimbursement for petitions and orders.—

(6) Subject to legislative appropriation, the clerk of the circuit court may, on a quarterly basis, submit to the Justice Administrative Commission a certified request for reimbursement for petitions and orders filed under ss. 394.459, 394.463, 394.467, and 394.917, ~~and 397.6814,~~ at the rate of $40 per petition or order. Such request for reimbursement shall be submitted in the form and manner prescribed by the Justice Administrative Commission pursuant to s. 28.35(2)(i).

Section 46. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455 ~~s. 394.455(49)~~.

Section 47. Paragraph (e) of subsection (4) of section

464.012, Florida Statutes, is amended to read:

464.012 Licensure of advanced practice registered nurses; fees; controlled substance prescribing.—

(4) In addition to the general functions specified in subsection (3), an advanced practice registered nurse may perform the following acts within his or her specialty:

(e) A psychiatric nurse, who meets the requirements in s. 394.455(37) ~~s. 394.455(36)~~, within the framework of an established protocol with a psychiatrist, may prescribe psychotropic controlled substances for the treatment of mental disorders.

Section 48. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455 ~~s. 394.455(49)~~, without an involuntary placement proceeding as provided by law.

Section 49. Subsection (3) of section 916.107, Florida Statutes, is amended to read:

916.107 Rights of forensic clients.—

(3) RIGHT TO EXPRESS AND INFORMED CONSENT.—

(a) A forensic client shall be asked to give express and informed written consent for treatment. If a client refuses such treatment as is deemed necessary and essential by the client's multidisciplinary treatment team for the appropriate care of the

client, such treatment may be provided under the following circumstances:

1. In an emergency situation in which there is immediate danger to the safety of the client or others, such treatment may be provided upon the ~~written~~ order of a licensed medical practitioner ~~physician~~ for up to 48 hours, excluding weekends and legal holidays. If, after the 48-hour period, the client has not given express and informed consent to the treatment initially refused, the administrator or designee of the civil or forensic facility shall, within 48 hours, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of the client. In the interim, the need for treatment shall be reviewed every 48 hours and may be continued without the consent of the client upon the continued ~~written~~ order of a licensed medical practitioner ~~physician~~ who has determined that the emergency situation continues to present a danger to the safety of the client or others.

2. In a situation other than an emergency situation, the administrator or designee of the facility shall petition the court for an order authorizing necessary and essential treatment for the client.

a. If the client has been receiving psychotropic

medication at the jail at the time of transfer to the forensic or civil facility and lacks the capacity to make an informed decision regarding mental health treatment at the time of admission, the admitting licensed medical practitioner ~~physician~~ shall order continued administration of psychotropic medication if, in the clinical judgment of the licensed medical practitioner ~~physician~~, abrupt cessation of that psychotropic medication could pose a risk to the health or safety of the client while a court order to medicate is pursued. The administrator or designee of the forensic or civil facility shall, within 5 days after a client's admission, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of a client with psychotropic medication. The jail physician shall provide a current psychotropic medication order at the time of transfer to the forensic or civil facility or upon request of the admitting licensed medical practitioner ~~physician~~ after the client is evaluated.

b. The court order shall allow such treatment for up to 90 days after the date that the order was entered. Unless the court is notified in writing that the client has provided express and informed written consent or that the client has been discharged by the committing court, the administrator or designee of the

facility shall, before the expiration of the initial 90-day order, petition the court for an order authorizing the continuation of treatment for an additional 90 days. This procedure shall be repeated until the client provides consent or is discharged by the committing court.

3. At the hearing on the issue of whether the court should enter an order authorizing treatment for which a client was unable to or refused to give express and informed consent, the court shall determine by clear and convincing evidence that the client has mental illness, intellectual disability, or autism, that the treatment not consented to is essential to the care of the client, and that the treatment not consented to is not experimental and does not present an unreasonable risk of serious, hazardous, or irreversible side effects. In arriving at the substitute judgment decision, the court must consider at least the following factors:

a. The client's expressed preference regarding treatment;

b. The probability of adverse side effects;

c. The prognosis without treatment; and

d. The prognosis with treatment.

The hearing shall be as convenient to the client as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the client's condition. The court may appoint a general or special magistrate

to preside at the hearing. The client or the client's guardian, and the representative, shall be provided with a copy of the petition and the date, time, and location of the hearing. The client has the right to have an attorney represent him or her at the hearing, and, if the client is indigent, the court shall appoint the office of the public defender to represent the client at the hearing. The client may testify or not, as he or she chooses, and has the right to cross-examine witnesses and may present his or her own witnesses.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment or nonpsychiatric medical procedures, and prior to performing the procedure, written permission shall be obtained from the client, if the client is legally competent, from the parent or guardian of a minor client, or from the guardian of an incompetent client. The administrator or designee of the forensic facility or a designated representative may, with the concurrence of the client's attending licensed medical practitioner ~~physician~~, authorize emergency surgical or nonpsychiatric medical treatment if such treatment is deemed lifesaving or for a situation threatening serious bodily harm to the client and permission of the client or the client's guardian could not be obtained before provision of the needed treatment.

Section 50. Subsection (5) of section 916.15, Florida

Statutes, is amended to read:

916.15 Involuntary commitment of defendant adjudicated not guilty by reason of insanity.—

(5) The commitment hearing shall be held within 30 days after the court receives notification that the defendant no longer meets the criteria for continued commitment. The defendant must be transported to the committing court's jurisdiction for the hearing. Each defendant returning to a jail shall continue to receive the same psychotropic medications as prescribed by the facility's licensed medical practitioner ~~facility physician~~ at the time of discharge from a forensic or civil facility, unless the jail physician determines there is a compelling medical reason to change or discontinue the medication for the health and safety of the defendant. If the jail physician changes or discontinues the medication and the defendant is later determined at the competency hearing to be incompetent to stand trial and is recommitted to the department, the jail physician may not change or discontinue the defendant's prescribed psychotropic medication upon the defendant's next discharge from the forensic or civil facility.

Section 51. For the 2024-2025 fiscal year, the sum of $50,000,000 of recurring funds from the General Revenue Fund are provided to the Department of Children and Families to implement the provisions of this act.

Section 52. This act shall take effect July 1, 2024.

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 & Human Services Committee

Representative Maney offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (23) of section 394.455, Florida Statutes, is amended to read:

394.455 Definitions.—As used in this part, the term:

(23) "Involuntary examination" means an examination performed under s. 394.463, s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811~~ to determine whether a person qualifies for involuntary services.

Section 2. Paragraph (e) is added to subsection (1) of section 394.4572, Florida Statutes, to read:

394.4572 Screening of mental health personnel. —

(1)

(e) A physician licensed under chapter 458 or chapter 459 or a nurse licensed under chapter 464 who was required to undergo background screening by the Department of Health as part of his or her initial licensure or the renewal of licensure, and who has an active and unencumbered license, is not subject to background screening pursuant to this section.

Section 3. Paragraph (d) of subsection (3) and paragraph (d) of subsection (5) of section 394.459, Florida Statutes, are amended to read:

394.459 Rights of patients.—

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.—

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's attending physician, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(d) If a patient's right to communicate with outside persons; receive, send, or mail sealed, unopened correspondence; or receive visitors is restricted by the facility, a qualified professional must record the restriction and its underlying reasons in the patient's clinical file within 24 hours. The

notice of the restriction must immediately ~~written notice of such restriction and the reasons for the restriction shall~~ be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative. ~~A qualified professional must document any restriction within 24 hours, and such restriction shall be recorded on the patient's clinical record with the reasons therefor.~~ The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 3 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (e).

Section 4. Subsection (3) of section 394.4598, Florida Statutes, is amended to read:

394.4598 Guardian advocate.—

(3) A facility requesting appointment of a guardian advocate must, prior to the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the

care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.

Section 5. Paragraph (d) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(d) The written notice of the filing of the petition for involuntary services for an individual being held must contain the following:

1. Notice that the petition for:

a. Involuntary services ~~inpatient treatment~~ pursuant to s. 394.467 has been filed with the circuit court and the address of such court ~~in the county in which the individual is hospitalized and the address of such court~~; or

b. Involuntary outpatient services pursuant to s. 394.467 ~~s. 394.4655~~ has been filed with the criminal county court, as

defined in s. 394.4655(1), ~~or the circuit court, as applicable, in the county in which the individual is hospitalized~~ and the address of such court.

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

Section 6. Subsection (2) and paragraph (d) of subsection (4) of section 394.461, Florida Statutes, are amended to read:

394.461 Designation of receiving and treatment facilities and receiving systems.—The department is authorized to designate and monitor receiving facilities, treatment facilities, and receiving systems and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. The department may issue a conditional designation

for up to 60 days to allow the implementation of corrective measures. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.

(2) TREATMENT FACILITY.—The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient shall not be admitted to a state treatment facility without previously undergoing a transfer evaluation. Before the close of the state's case-in-chief in ~~a court~~ hearing for involuntary placement ~~in a state treatment facility~~, the state may establish that the transfer evaluation was performed and the document was properly executed by providing the court with a copy of the transfer evaluation. The court may not ~~shall receive and~~ consider the substantive information ~~documented~~ in the transfer evaluation unless the evaluator testifies at the hearing. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.

(4) REPORTING REQUIREMENTS.—

(d) The department shall issue an annual report based on the data required pursuant to this subsection. The report shall include individual facilities' data, as well as statewide totals. The report shall be posted on the department's website

~~submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives~~.

Section 7. Paragraph (a) of subsection (2) and subsection (3) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(2) The clinical record shall be released when:

(a) The patient or the patient's guardian or legal custodian authorizes the release. The guardian, ~~or~~ guardian advocate, or legal custodian shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian, ~~or~~ guardian advocate, or legal custodian may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care. A receiving facility must document that, within 24 hours of admission, individuals admitted on a voluntary basis have been provided with the option to authorize the release of information from their clinical record to the individual's health care surrogate or proxy, attorney, representative, or other known emergency contact.

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has communicated to a service provider a specific threat to cause serious bodily injury or death to an identified or a readily available person, if the service provider reasonably believes, or should reasonably believe

according to the standards of his or her profession, that the patient has the apparent intent and ability to imminently or immediately carry out such threat. When such communication has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the criteria for involuntary services ~~outpatient placement~~ or for preparing the proposed services ~~treatment~~ plan pursuant to s. 394.4655 or s. 394.467 ~~s. 394.4655~~, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider under s. 394.4655 or s. 394.467 ~~identified in s. 394.4655(7)(b)2.~~, in accordance with state and federal law.

Section 8. Section 394.462, Florida Statutes, is amended to read:

394.462 Transportation.—A transportation plan shall be developed and implemented by each county in collaboration with the managing entity in accordance with this section. A county may enter into a memorandum of understanding with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into a memorandum of understanding for this purpose, the counties shall notify the managing entity and provide it with a copy of the agreement. The transportation plan shall describe methods of transport to a facility within the designated receiving system for individuals subject to involuntary examination under s. 394.463 or involuntary admission under s. 397.6772, s. 397.679, s. 397.6798, or s. 397.6957 ~~s. 397.6811~~, and may identify responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan may rely on emergency medical transport services or private transport companies, as appropriate. The plan shall comply with the transportation provisions of this section and ss. 397.6772, 397.6795, ~~397.6822,~~ and 397.697.

(1) TRANSPORTATION TO A RECEIVING FACILITY.—

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the

appropriate facility within the designated receiving system pursuant to a transportation plan.

(b)1. The designated law enforcement agency may decline to transport the person to a receiving facility only if:

a. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county or as otherwise provided in the transportation plan developed by the county; and

b. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

2. The entity providing transportation may seek reimbursement for transportation expenses. The party responsible for payment for such transportation is the person receiving the transportation. The county shall seek reimbursement from the following sources in the following order:

a. From a private or public third-party payor, if the person receiving the transportation has applicable coverage.

b. From the person receiving the transportation.

c. From a financial settlement for medical care, treatment, hospitalization, or transportation payable or accruing to the injured party.

(c) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transport of the patient. Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(e) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(f) When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 or s. 397.675 and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.

(g) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination

pursuant to s. 394.463, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan. Persons who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan.

(h) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person must first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the appropriate facility within the designated receiving system pursuant to a transportation plan. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the person where he or she is held.

(i) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital

for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

(j) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.

(k) The appropriate facility within the designated receiving system pursuant to a transportation plan must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

(l) The appropriate facility within the designated receiving system pursuant to a transportation plan must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic screening or triage sufficient to refer the person to the appropriate services.

(m) Each law enforcement agency designated pursuant to paragraph (a) shall establish a policy that reflects a single set of protocols for the safe and secure transportation and transfer of custody of the person. Each law enforcement agency shall provide a copy of the protocols to the managing entity.

(n) When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to facilities within the designated receiving system, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

(o) This section may not be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with s. 401.445.

(2) TRANSPORTATION TO A TREATMENT FACILITY.—

(a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting a voluntary or involuntary patient to a treatment facility, the transportation plan established by the governing board of the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities in a safe and dignified manner.

(b) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient. Such company must be insured and provide no less than $100,000

in liability insurance with respect to the transport of patients.

(c) A company that contracts with one or more counties to transport patients in accordance with this section shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(d) County or municipal law enforcement and correctional personnel and equipment may not be used to transport patients adjudicated incapacitated or found by the court to meet the criteria for involuntary services ~~placement~~ pursuant to s. 394.467, except in small rural counties where there are no cost-efficient alternatives.

(3) TRANSFER OF CUSTODY.—Custody of a person who is transported pursuant to this part, along with related documentation, shall be relinquished to a responsible individual at the appropriate receiving or treatment facility.

Section 9. Paragraphs (a) and (f) of subsection (1) and subsection (5) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any adult ~~person 18 years of age or older~~ who applies by express and informed consent for admission or any minor ~~person age 17 or younger~~ whose parent or legal guardian applies

for admission. Such person may be admitted to the facility if found to show evidence of mental illness and to be suitable for treatment, and:

1. If the person is an adult, is found~~,~~ to be competent to provide express and informed consent; or

2. If the person is a minor, the parent or legal guardian provides express and informed consent and the facility performs~~, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or younger may be admitted only after~~ a clinical review to verify the voluntariness of the minor's assent.

(f) Within 24 hours after admission of a voluntary patient, the treating ~~admitting~~ physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(5) TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist with at least 3 years of

postdoctoral experience in the practice of clinical psychology, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the ~~written~~ order of a physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, if it is determined that such treatment is necessary for the safety of the patient or others.

Section 10. Subsection (1), paragraphs (a), (e), (f), (g), and (h) of subsection (2), and subsection (4) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person

into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer may ~~shall~~ take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. A law enforcement officer transporting a person pursuant to this section ~~subparagraph~~ shall restrain the person in the least restrictive manner available and appropriate under the circumstances. If transporting a minor and the parent or legal guardian of the minor is present, before departing, the law enforcement officer shall provide the parent or legal guardian of the minor with the name, address, and contact information for

the facility within the designated receiving system to which the law enforcement officer is transporting the minor, subject to any safety and welfare concerns for the minor. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as

voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody and include all emergency contact information required under subparagraph 2. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts pursuant to s. 119.0712(2)(d). The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information

about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(e) The department shall receive and maintain the copies of ex parte orders, involuntary ~~outpatient~~ services orders issued pursuant to ss. 394.4655 and 394.467 ~~s. 394.4655, involuntary inpatient placement orders issued pursuant to s. 394.467~~, professional certificates, law enforcement officers' reports, and reports relating to the transportation of patients. These documents shall be considered part of the clinical record, governed by the provisions of s. 394.4615. These documents shall be provided to the institute established under s. 1004.44 by the department and used by the institute to prepare annual reports analyzing the data obtained from these documents, without including the personal identifying information of the patient. ~~identifying patients, and~~ The information in the reports may include, but need not be limited to, a state level analysis of involuntary examinations, including a description of demographic characteristics of individuals and the geographic locations of involuntary examinations; counts of the number of involuntary examinations at each receiving facility; and reporting and analysis of trends for involuntary examinations within the state. The report shall also include counts of and provide demographic, geographic, and other relevant information about individuals with a developmental disability, as defined in s.

393.063, or a traumatic brain injury or dementia who were taken to a receiving facility for involuntary examination pursuant to s. 394.463 and determined not to have a co-occurring mental illness. The institute shall post the reports on its website and provide copies of such reports to the department, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives by November 30 of each year.

(f) A patient shall be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an

involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. The release may be approved through telehealth.

(g) The examination period must be for up to 72 hours and begins when a patient arrives at the receiving facility. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court ~~if inpatient treatment is deemed necessary~~ or with the criminal county court, as defined in s. 394.4655(1), as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum

improvement of the patient's condition shall be made available. The ~~When a~~ petition ~~is to be filed for involuntary outpatient placement, it~~ shall be filed by one of the petitioners specified in s. 394.467, and the court shall dismiss an untimely filed petition ~~s. 394.4655(4)(a)~~. ~~A petition for involuntary inpatient placement shall be filed by the facility administrator.~~ If a patient's 72-hour examination period ends on a weekend or holiday, including the hours before the ordinary business hours on the morning of the next working day, and the receiving facility:

a. Intends to file a petition for involuntary services, such patient may be held at the ~~a receiving~~ facility through the next working day thereafter and the ~~such~~ petition ~~for involuntary services~~ must be filed no later than such date. If the ~~receiving~~ facility fails to file the ~~a~~ petition by ~~for involuntary services at~~ the ordinary close of business on the next working day, the patient shall be released from the receiving facility following approval pursuant to paragraph (f).

b. Does not intend to file a petition for involuntary services, the ~~a~~ receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, and approval pursuant to paragraph (f), are not possible until the next working day.

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified in paragraph (g). The examination period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary ~~outpatient~~ services pursuant to s. 394.467 ~~s. 394.4655(2) or involuntary inpatient placement pursuant to s. 394.467(1)~~, the patient may be offered voluntary outpatient or inpatient services ~~or placement~~, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary ~~inpatient~~ services ~~or involuntary outpatient placement~~ must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before stabilization if the requirements of s. 395.1041(3)(c) have been met.

(4) DATA ANALYSIS.—

(a) The department shall provide the data ~~Using data~~ collected under paragraph (2)(a) and s. 1006.07(10), and child welfare data related to involuntary examinations, to the institute established under 1004.44. ~~department~~ The Agency for Health Care Administration shall provide Medicaid data to the institute, requested by the institute, related to involuntary examination of children enrolled in Medicaid for the purpose of administering the program and improving service provision for such children. The department and agency shall enter into any necessary agreements with the institute to provide such data. The institute shall use such data to~~,~~ at a minimum, analyze data on both the initiation of involuntary examinations of children and the initiation of involuntary examinations of students who are removed from a school; identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child or student; study root causes for such patterns, trends, or repeated involuntary examinations; and make recommendations to encourage the use of alternatives to eliminate inappropriate initiations of such examinations.

(b) The institute shall analyze service data on individuals who are high utilizers of crisis stabilization services provided in designated receiving facilities, and shall, at a minimum, identify any patterns or trends and make recommendations to decrease avoidable admissions. Recommendations may be addressed in the department's contracts

with the behavioral health managing entities and in the contracts between the Agency for Health Care Administration and the Medicaid managed medical assistance plans.

(c) The institute ~~department~~ shall publish ~~submit~~ a report on its findings and recommendations on its website and submit the report to the Governor, the President of the Senate, ~~and~~ the Speaker of the House of Representatives, the department and the Agency for Health Care Administration by November 1 of each odd-numbered year.

Section 11. Section 394.4655, Florida Statutes, is amended to read:

394.4655 Involuntary outpatient services.—

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

(a) "Court" means a circuit court or a criminal county court.

(b) "Criminal county court" means a county court exercising its original jurisdiction in a misdemeanor case under s. 34.01.

(c) "Involuntary outpatient placement" means involuntary outpatient services as defined in s. 394.467, F.S.

(2) A criminal county court may order an individual to involuntary outpatient placement under s. 394.467. ~~CRITERIA FOR INVOLUNTARY OUTPATIENT SERVICES.—A person may be ordered to involuntary outpatient services upon a finding of the court, by~~

~~clear and convincing evidence, that the person meets all of the following criteria:~~

~~(a) The person is 18 years of age or older.~~

~~(b) The person has a mental illness.~~

~~(c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.~~

~~(d) The person has a history of lack of compliance with treatment for mental illness.~~

~~(e) The person has:~~

~~1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or~~

~~2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months.~~

~~(f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary or is unable to determine for himself or herself whether services are necessary.~~

~~(g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).~~

~~(h) It is likely that the person will benefit from involuntary outpatient services.~~

~~(i) All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.~~

~~(3) INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment~~

~~of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate that authorizes the facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.~~

~~2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.~~

~~3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's~~

~~guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the~~

~~administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.~~

~~(c)1. The administrator of the treatment facility shall provide a copy of the involuntary outpatient services certificate and a copy of the state mental health discharge form to the managing entity in the county where the patient will be residing. For persons who are leaving a state mental health~~

~~treatment facility, the petition for involuntary outpatient services must be filed in the county where the patient will be residing.~~

~~2. The service provider that will have primary responsibility for service provision shall be identified by the designated department representative before the order for involuntary outpatient services and must, before filing a petition for involuntary outpatient services, certify to the court whether the services recommended in the patient's discharge plan are available and whether the service provider agrees to provide those services. The service provider must develop with the patient, or the patient's guardian advocate, if appointed, a treatment or service plan that addresses the needs identified in the discharge plan. The plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in this chapter, who consults with, or is employed or contracted by, the service provider.~~

~~3. If the service provider certifies that the services in the proposed treatment or service plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(4) PETITION FOR INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a) A petition for involuntary outpatient services may be filed by:~~

~~1. The administrator of a receiving facility; or~~

~~2. The administrator of a treatment facility.~~

~~(b) Each required criterion for involuntary outpatient services must be alleged and substantiated in the petition for involuntary outpatient services. A copy of the certificate recommending involuntary outpatient services completed by a qualified professional specified in subsection (3) must be attached to the petition. A copy of the proposed treatment plan must be attached to the petition. Before the petition is filed, the service provider shall certify that the services in the proposed plan are available. If the necessary services are not available, the petition may not be filed. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(c) The petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside. When the petition has been filed, the clerk of the court shall provide copies of the petition and the proposed treatment plan to the department, the managing entity,~~

~~the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel. A fee may not be charged for filing a petition under this subsection.~~

~~(5) APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary outpatient services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of the appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary outpatient services. An attorney who represents the patient must be provided access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(6) CONTINUANCE OF HEARING.—The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.~~

~~(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. The court shall hold the hearing on involuntary outpatient services within 5 working days after the filing of the petition, unless a continuance is granted. The hearing must~~

~~be held in the county where the petition is filed, must be as convenient to the patient as is consistent with orderly procedure, and must be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient and if the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding.~~

~~2. The court may appoint a magistrate to preside at the hearing. One of the professionals who executed the involuntary outpatient services certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under~~

~~oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.~~

~~(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court shall issue an order for involuntary outpatient services. The court order shall be for a period of up to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.~~

~~2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through~~

~~existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~3. If, in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan~~

~~to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~(c) If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services under this section but, instead, meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination under s. 394.463. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings are governed by chapter 397.~~

~~(d) At the hearing on involuntary outpatient services, the court shall consider testimony and evidence regarding the patient's competence to consent to services. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598. The guardian advocate shall be appointed or discharged in accordance with s. 394.4598.~~

~~(c) The administrator of the receiving facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient services. Such documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychologist or a clinical social worker.~~

~~(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.~~

~~(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider shall, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.~~

~~2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.~~

~~3. A certificate shall be attached to the petition which includes a statement from the person's physician or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving~~

~~involuntary services, and an individualized plan of continued treatment.~~

~~4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.~~

~~(b) Within 1 court working day after the filing of a petition for continued involuntary outpatient services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed or the court order expires or the patient is discharged from involuntary outpatient services. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(c) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the~~

~~order for involuntary outpatient services. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7), except that the time period included in paragraph (2)(c) is not applicable in determining the appropriateness of additional periods of involuntary outpatient placement.~~

~~(d) Notice of the hearing must be provided as set forth in s. 394.4599. The patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.~~

~~(e) The same procedure must be repeated before the expiration of each additional period the patient is placed in treatment.~~

~~(f) If the patient has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. Section 394.4598 governs the discharge of the guardian advocate if the patient's competency to consent to treatment has been restored.~~

Section 12. Section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary services ~~inpatient placement~~.—

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

(a) "Court" means a circuit court.

(b) "Involuntary inpatient placement" means placement in a secure receiving or treatment facility providing stabilization and treatment services to a person 18 years of age or older who does not voluntarily consent to services under this chapter, or a minor who does not voluntarily assent to services under this chapter.

(c) "Involuntary outpatient services" means services provided in the community to a person who does not voluntarily consent to or participate in services under this chapter.

(d) "Services plan" means an individualized plan detailing the recommended behavioral health services and supports based on a thorough assessment of the needs of the patient, to safeguard and enhance the patient's health and well-being in the community.

(2)~~(1)~~ CRITERIA FOR INVOLUNTARY SERVICES.—A person may be ordered by a court to be provided ~~for~~ involuntary services ~~inpatient placement for treatment~~ upon a finding of the court, by clear and convincing evidence, that the person meets the following criteria:

(a) *Involuntary outpatient services.*—A person ordered to involuntary outpatient services must meet the following criteria:

1. The person has a mental illness and because of his or her mental illness:

a. Is unlikely to voluntarily participate in a recommended services plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary; or

b. He or she is unable to determine for himself or herself whether services are necessary.

2. The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

3. The person has a history of lack of compliance with treatment for mental illness.

4. In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).

5. It is likely that the person will benefit from involuntary outpatient services.

6. All available less restrictive alternatives that would offer an opportunity for improvement of the person's condition have been deemed to be inappropriate or unavailable.

(b) *Involuntary inpatient placement.*—A person ordered to involuntary inpatient placement must meet the following criteria:

1. ~~(a)~~ The person ~~He or she~~ has a mental illness and because of his or her mental illness:

~~1.~~a. He or she has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of inpatient placement for treatment; or

b. He or she Is unable to determine for himself or herself whether inpatient placement is necessary; and

2.a. He or she is incapable of surviving alone or with the help of willing, able, and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

b. Without treatment, there ~~There~~ is a substantial likelihood that in the near future the person ~~he or she~~ will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting to cause, or threatening to cause such harm; and

c. ~~(b)~~ All available less restrictive treatment alternatives that would offer an opportunity for improvement of

the person's ~~his or her~~ condition have been deemed ~~judged~~ to be inappropriate or unavailable.

(3)~~(2)~~ RECOMMENDATION FOR INVOLUNTARY SERVICES AND ~~ADMISSION TO A~~ TREATMENT ~~FACILITY~~.~~—~~A patient may be recommended for involuntary inpatient placement, involuntary outpatient services, or a combination of both.

(a) A patient may be retained by a facility for involuntary services ~~or involuntarily placed in a treatment facility~~ upon the recommendation of the administrator of the facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. However, if a patient who is being recommended for only involuntary outpatient services has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services.

(b) The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient ~~within the preceding 72 hours, that the criteria for involuntary~~ services ~~inpatient placement are met~~. For involuntary inpatient placement, the patient must have been examined within the

preceding 72 hours. For involuntary outpatient services the patient must have been examined within the preceding 30 days.

(c) If ~~However, if the administrator certifies that~~ a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide a ~~the~~ second opinion, the petitioner must certify that a clinical psychologist is not available and the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a clinical psychologist, or ~~by~~ a psychiatric nurse.

(d) Any opinion authorized in this subsection may be conducted through a face-to-face or in-person examination, ~~in person,~~ or by electronic means. Recommendations for involuntary services must be ~~Such recommendation shall be~~ entered on a petition for involuntary services ~~inpatient placement certificate~~, which shall be made a part of the patient's clinical record. The petition must either authorize the facility to retain the patient pending completion of a hearing or authorize ~~that authorizes~~ the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

(4)~~(3)~~ PETITION FOR INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a) A petition for involuntary services may be filed by:

1. The administrator of a receiving ~~the~~ facility;

2. The administrator of a treatment facility; or

3. A service provider who is treating the person being petitioned.

(b) A ~~shall file a~~ petition for involuntary inpatient placement, or inpatient placement followed by outpatient services, must be filed in the court in the county where the patient is located.

(c) A petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside.

(d)1. The petitioner must state in the petition:

a. Whether the petitioner is recommending inpatient placement, outpatient services, or both.

b. The length of time recommended for each type of involuntary services.

c. The reasons for the recommendation.

2. If recommending involuntary outpatient services, or a combination of involuntary inpatient placement and outpatient services, the petitioner must identify the service provider that has agreed to provide services for the person under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the

individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. If recommending an immediate order to involuntary outpatient services, the petitioner shall prepare a written proposed services plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The services plan must specify the likely needed level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. If the services in the proposed services plan are not available, the petitioner may not file the petition. The petitioner must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested service. The service provider who accepts the patient for involuntary outpatient services is responsible for the development of a comprehensive treatment plan.

(e) Each required criterion for the recommended involuntary services must be alleged and substantiated in the petition. A copy of the recommended services plan, if applicable, must be attached to the petition. The court must accept petitions and other documentation with electronic signatures.

(f) When the petition has been filed ~~Upon filing~~, the clerk of the court shall provide copies of the petition and, if applicable, the recommended services plan to the department, the managing entity, the patient, the patient's guardian or representative, ~~and~~ the state attorney, and the public defender or the patient's private counsel ~~of the judicial circuit in which the patient is located~~. A fee may not be charged for the filing of a petition under this subsection.

(5)~~(4)~~ APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary services ~~inpatient placement~~, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel or ineligible. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary services. Any attorney who represents ~~representing~~ the patient shall be provided ~~have~~ access to the patient, witnesses, and

records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(6) ~~(5)~~ CONTINUANCE OF HEARING.—The patient and the state are independently ~~is~~ entitled~~, with the concurrence of the patient's counsel,~~ to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires the concurrence of the patient's counsel. The state's continuance may be for a period of up to 5 court working days and requires a showing of good cause and due diligence by the state before requesting the continuance. The state's failure to timely review any readily available document or failure to attempt to contact a known witness does not warrant a continuance.

(7) ~~(6)~~ HEARING ON INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a)1. The court shall hold a ~~the~~ hearing on the involuntary services petition ~~inpatient placement~~ within 5 court working days after the filing of the petition, unless a continuance is granted.

2. The court must hold any hearing on involuntary outpatient services in the county where the petition is filed. A hearing on involuntary inpatient placement, or a combination of involuntary inpatient placement and involuntary outpatient services, ~~Except for good cause documented in the court file,~~

~~the hearing~~ must be held in the county or the facility, as appropriate, where the patient is located, except for good cause documented in the court file.

3. A hearing on involuntary services must be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient, or the patient knowingly, intelligently, and voluntarily waives his or her right to be present, and if the patient's counsel does not object, the court may waive the attendance ~~presence~~ of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding. The facility shall make the respondent's clinical records available to the state attorney and the respondent's attorney so that the state can evaluate and prepare its case. However, these records shall remain confidential, and the state attorney may not use any record obtained under this part for criminal investigation or prosecution purposes, or for any purpose other than the patient's civil commitment under this chapter ~~petitioning facility administrator, as the real party in interest in the proceeding~~. (b)~~3.~~ The court may appoint a magistrate to preside at the hearing. Upon a finding of good

cause, the court may permit all witnesses, including, but not limited to, medical professionals who are or have been involved with the patient's treatment, to remotely attend and testify at the hearing under oath via audio-video teleconference. A witness intending to remotely attend and testify must provide the parties with all relevant documents by the close of business on the day before the hearing. One of the professionals who executed the ~~petition for~~ involuntary services ~~inpatient placement~~ certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided for by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from persons, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

(c) ~~(b)~~ At the hearing, the court shall consider testimony and evidence regarding the patient's competence to consent to services and treatment. If the court finds that the patient is

incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598.

(8) ORDERS OF THE COURT.—

(a)1. If the court concludes that the patient meets the criteria for involuntary services, the court may order a patient to involuntary inpatient placement, involuntary outpatient services, or a combination of involuntary services depending on the criteria met and which type of involuntary services best meet the needs of the patient. However, if the court orders the patient to involuntary outpatient services, the court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The petitioner must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court.

2. The order must specify the nature and extent of the patient's mental illness.

3.a. An order for only involuntary outpatient services shall be for a period of up to 90 days.

b. An order for involuntary inpatient placement, or a combination of inpatient placement and outpatient services, may be up to 6 months.

4. An order for a combination of involuntary services shall specify the length of time the patient shall be ordered for involuntary inpatient placement and involuntary outpatient services.

5. The order of the court and the patient's services plan, if applicable, must be made part of the patient's clinical record.

(b) If the court orders a patient into involuntary inpatient placement, the court ~~it~~ may order that the patient be transferred to a treatment facility, or~~,~~ if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate facility, or that the patient receive services~~,~~ on an involuntary basis~~, for up to 90 days~~. ~~However, any order for involuntary mental health services in a treatment facility may be for up to 6 months. The order shall specify the nature and extent of the patient's mental illness.~~ The court may not order an individual with a developmental disability as defined in s. 393.063 or a traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility. ~~The facility shall discharge a patient any time the patient no longer meets~~

~~the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.~~

(c) If at any time before the conclusion of a ~~the~~ hearing on involuntary services, ~~inpatient placement~~ it appears to the court that the patient ~~person does not meet the criteria for involuntary inpatient placement under this section, but~~ instead meets the criteria for involuntary ~~outpatient services, the court may order the person evaluated for involuntary outpatient services pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary~~ admission or treatment pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment ~~for a period of 5 days~~ pursuant to s. 397.6757 ~~s. 397.6811~~. Thereafter, all proceedings are governed by chapter 397.

~~(d) At the hearing on involuntary inpatient placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598.~~

(d) ~~(c)~~ The administrator of the petitioning facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient

services or the administrator of a treatment facility if the patient is ordered for involuntary inpatient placement~~, whether by civil or criminal court~~. The documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychiatric nurse, a clinical psychologist, a marriage and family therapist, a mental health counselor, or a clinical social worker. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or criminal court order, who is not accompanied by adequate orders and documentation.

(9) SERVICE PLAN MODIFICATION—After the order for involuntary outpatient services is issued, the service provider and the patient may modify the services plan. For any material modification of the services plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the services plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (4).

(10) NONCOMPLIANCE WITH INVOLUNTARY OUTPATIENT SERVICES.—If, in the clinical judgment of a physician, a patient receiving involuntary outpatient services has failed or has refused to comply with the services plan ordered by the court, and efforts

were made to solicit compliance, the service provider must report such noncompliance to the court. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing services plan and must attempt to continue to engage the patient in treatment. For any material modification of the services plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the services plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (4).

(11)~~(7)~~ PROCEDURE FOR CONTINUED INVOLUNTARY SERVICES ~~INPATIENT PLACEMENT~~.—

(a) A petition for continued involuntary services shall be filed if the patient continues to meets the criteria for involuntary services.

(b)1. If a patient receiving involuntary outpatient services continues to meet the criteria for involuntary outpatient services, the service provider shall file in the court that issued the initial order for involuntary outpatient

services a petition for continued involuntary outpatient services.

2. If a patient in involuntary inpatient placement

~~(a) Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in accordance with s. 120.57(1), except that any order entered by the administrative law judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity are governed by s. 916.15.~~

~~(b) If the patient~~ continues to meet the criteria for involuntary inpatient placement and is being treated at a ~~treatment~~ receiving facility, the administrator shall, before the expiration of the period the ~~treatment~~ receiving facility is authorized to retain the patient, file in the court that issued the initial order for involuntary inpatient placement, a petition requesting authorization for continued involuntary inpatient placement.

3. Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in accordance with s. 120.57(1), except that any order entered by the judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after

successfully pleading not guilty by reason of insanity are governed by s. 916.15.

4. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.

5. The existing involuntary services order shall remain in effect until disposition on the petition for continued involuntary services.

(c) The petition ~~request~~ must be accompanied by a statement from the patient's physician, psychiatrist, psychiatric nurse, or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services ~~involuntarily placed~~, and an individualized plan of continued treatment~~.~~ developed in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the petition and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.

(d) The court shall appoint counsel to represent the person who is the subject of the petition for continued involuntary services in accordance to the provisions set forth in subsection (5), unless the person is otherwise represented by counsel or ineligible.

(e) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the order for involuntary outpatient services. However, the patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.

(f) Hearings on petitions for continued involuntary inpatient placement in receiving facilities must be held in the county or the facility, as appropriate, where the patient is located.

(g) The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7).

(h) Notice of the hearing must be provided as set forth ~~provided~~ in s. 394.4599.

(i) If a patient's attendance at the hearing is voluntarily waived, the ~~administrative law~~ judge must determine that the patient knowingly, intelligently, and voluntarily waived his or her right to be present, ~~waiver is knowing and voluntary~~ before waiving the presence of the patient from all or a portion of the hearing. Alternatively, if at the hearing the ~~administrative law~~ judge finds that attendance at the hearing is not consistent with the best interests of the patient, the ~~administrative law~~ judge may waive the presence of the patient from all or any portion of the hearing, unless the patient, through counsel, objects to the waiver of presence. The

testimony in the hearing must be under oath~~,~~ and the proceedings must be recorded.

~~(c) Unless the patient is otherwise represented or is ineligible, he or she shall be represented at the hearing on the petition for continued involuntary inpatient placement by the public defender of the circuit in which the facility is located.~~

(k)~~(d)~~ If at a hearing it is shown that the patient continues to meet the criteria for involuntary services ~~inpatient placement~~, the court ~~administrative law judge~~ shall issue an ~~sign the~~ order for continued involuntary outpatient services ~~inpatient placement~~ for up to 90 days or~~. However, any order for~~ involuntary inpatient placement, or ~~mental health services in~~ a combination of involuntary services ~~treatment facility may be~~ for up to 6 months. The same procedure shall be repeated before the expiration of each additional period the patient is retained.

(l) If the patient has been ordered to undergo involuntary services and has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. If the patient's competency to consent to treatment is restored, the discharge of the guardian advocate shall be governed by s. 394.4598. If the patient has been ordered to undergo involuntary inpatient placement only and the patient's competency to consent to treatment is restored, the administrative law judge may issue a

recommended order, to the court that found the patient incompetent to consent to treatment, that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

(m) ~~(c)~~ If continued involuntary inpatient placement is necessary for a patient in involuntary inpatient placement who was admitted while serving a criminal sentence, but his or her sentence is about to expire, or for a minor involuntarily placed, but who is about to reach the age of 18, the administrator shall petition the administrative law judge for an order authorizing continued involuntary inpatient placement. The procedure required in this subsection must be followed before the expiration of each additional period the patient is involuntarily receiving services.

(12) ~~(8)~~ RETURN TO FACILITY.—If a patient has been ordered to undergo involuntary inpatient placement ~~involuntarily~~ held at a treatment facility under this part leaves the facility without the administrator's authorization, the administrator may authorize a search for the patient and his or her return to the facility. The administrator may request the assistance of a law enforcement agency in this regard.

(13) DISCHARGE—The patient shall be discharged upon expiration of the court order or at any time the patient no longer meets the criteria for involuntary services, unless the patient has transferred to voluntary status. Upon discharge, the

service provider or facility shall send a certificate of discharge to the court.

Section 13. Subsection (2) of section 394.468, Florida Statutes, is amended and subsection (3) is added to that section to read:

394.468 Admission and discharge procedures.—

(2) Discharge planning and procedures for any patient's release from a receiving facility or treatment facility must include and document the patient's needs, and actions to address such needs, for ~~consideration of~~, at a minimum:

(a) Follow-up behavioral health appointments;

(b) Information on how to obtain prescribed medications; and

(c) Information pertaining to:

1. Available living arrangements;

2. Transportation; and

(d) Referral to:

1. Care coordination services. The patient must be referred for care coordination services if the patient meets the criteria as a member of a priority population as determined by the department under s. 394.9082(3)(c) and is in need of such services.

2.~~3.~~ Recovery support opportunities under s. 394.4573(2)(l), including, but not limited to, connection to a peer specialist.

(3) During the discharge transition process and while the patient is present unless determined inappropriate by a physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, a receiving facility shall coordinate, face-to-face or through electronic means, discharge plans to a less restrictive community behavioral health provider, a peer specialist, a case manager, or a care coordination service. The transition process must include all of the following criteria:

(a) Implementation of policies and procedures outlining strategies for how the receiving facility will comprehensively address the needs of patients who demonstrate a high use of receiving facility services to avoid or reduce future use of crisis stabilization services.

(b) Developing and including in discharge paperwork a personalized crisis prevention plan that identifies stressors, early warning signs or symptoms, and strategies to deal with crisis.

(c) Requiring a staff member to seek to engage a family member, legal guardian, legal representative, or natural support in discharge planning and meet face to face or through electronic means to review the discharge instructions, including prescribed medications, follow-up appointments, and any other recommended services or follow-up resources, and document the outcome of such meeting.

(d) When the recommended level of care at discharge is not immediately available to the patient, the receiving facility must, at a minimum, initiate a referral to an appropriate provider to meet the needs of the patient to continue care until the recommended level of care is available.

Section 14. Section 394.4915, Florida Statutes, is created to read:

394.4915 Office of Children's Behavioral Health Ombudsman.-The Office of Children's Behavioral Health Ombudsman is established within the department for the purpose of being a central point to receive complaints on behalf of children and adolescents with behavioral health disorders receiving state-funded services and use such information to improve the child and adolescent mental health treatment and support system. The department and managing entities shall include information about and contact information for the office placed prominently on their websites on easily accessible web pages related to children and adolescent behavioral health services. To the extent permitted by available resources, the office shall, at a minimum:

(1) Receive and direct to the appropriate contact within the department, the Agency for Health Care Administration, or the appropriate organizations providing behavioral health services complaints from children and adolescents and their

families about the child and adolescent mental health treatment and support system.

(2) Maintain records of complaints received and the actions taken.

(3) Be a resource to identify and explain relevant policies or procedures to children, adolescents, and their families about the child and adolescent mental health treatment and support system.

(4) Provide recommendations to the department to address systemic problems within the child and adolescent mental health treatment and support system that are leading to complaints. The department shall include an analysis of complaints and recommendations in the report required under s. 394.4573.

(5) Engage in functions that may improve the child and adolescent mental health treatment and support system.

Section 15. Subsection (3) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(3) Assessments must be performed by:

(a) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~;

(b) A professional licensed under chapter 491; or

(c) A person who is under the direct supervision of a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455, ~~qualified professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491.

Section 16. Subsection (5) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(5) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist, as those terms are defined in s. 394.455, ~~professional as defined in s. 394.455(5), (7), (33), (36), or (37)~~ or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 17. Paragraph (a) of subsection (2) of section 394.499, Florida Statutes, is amended to read:

394.499 Integrated children's crisis stabilization unit/juvenile addictions receiving facility services.—

(2) Children eligible to receive integrated children's crisis stabilization unit/juvenile addictions receiving facility services include:

(a) A minor whose parent makes ~~person under 18 years of age for whom~~ voluntary application based on the parent's express and informed consent, and the requirements of s. 394.4625(1)(a)

are met ~~is made by his or her guardian, if such person is found to show evidence of mental illness and to be suitable for treatment pursuant to s. 394.4625. A person under 18 years of age may be admitted for integrated facility services only after a hearing to verify that the consent to admission is voluntary.~~

Section 18. Paragraphs (a) and (d) of subsection (1) of section 394.875, Florida Statutes, are amended to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician, ~~or~~ psychiatrist, or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay ~~and shall be limited in size to a maximum of 30 beds~~.

~~(d) The department is directed to implement a demonstration project in circuit 18 to test the impact of~~

~~expanding beds authorized in crisis stabilization units from 30 to 50 beds. Specifically, the department is directed to authorize existing public or private crisis stabilization units in circuit 18 to expand bed capacity to a maximum of 50 beds and to assess the impact such expansion would have on the availability of crisis stabilization services to clients.~~

Section 19. Section 394.90826, Florida Statutes, is created to read:

394.90826 Behavioral Health Interagency Collaboration.--

(1) The department and the Agency for Health Care Administration shall jointly establish behavioral health interagency collaboratives throughout the state with the goal of identifying and addressing ongoing challenges within the behavioral health system at the local level to improve the accessibility, availability, and quality of behavioral health services. The objectives of the regional collaboratives are to:

a. Facilitate enhanced interagency communication and collaboration.

b. Develop and promote regional strategies tailored to address community-level challenges in the behavioral health system.

(2) The regional collaborative membership shall at a minimum be composed of representatives from the following, serving the region:

a. Department of Children and Families;

b. Agency for Health Care Administration;

c. Agency for Persons with Disabilities;

d. Department of Elder Affairs;

e. Department of Health;

f. Department of Education;

g. School districts;

h. Area Agencies on Aging;

i. Community-based care lead agencies, as defined in s. 409.986(3)(d);

j. Managing entities, as defined in s. 394.9082;

k. Behavioral health services providers;

l. Hospitals;

m. Medicaid Managed Medical Assistance Plans;

n. Police departments; and

o. Sheriffs' Offices.

(3) Each regional collaborative shall define the objectives of that collaborative based upon the specific needs of the region and local communities located within the region, to achieve the specified goals.

(4) The department shall define the region to be served by each collaborative and shall be responsible for facilitating meetings.

(5) All entities represented on the regional collaboratives shall provide assistance as appropriate and

reasonably necessary to fulfill the goals of the regional collaboratives.

Section 20. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification ~~services~~," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(26)(a)4. ~~397.311(26)(a)3.~~, 397.311(26)(a)1., and 394.455(41) ~~394.455(40)~~, respectively.

Section 21. Subsection (3) of section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(3) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services in the most appropriate and least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

Section 22. Subsections (19) and (23) of section 397.311, Florida Statutes, are amended to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(19) "Impaired" or "substance abuse impaired" means having a substance use disorder or a condition involving the use of alcoholic beverages, illicit or prescription drugs, or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems or ~~and~~ cause socially dysfunctional behavior.

(23) "Involuntary treatment services" means an array of behavioral health services that may be ordered by the court for persons with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders.

Section 23. Subsection (6) is added to section 397.401, Florida Statutes, to read:

397.401 License required; penalty; injunction; rules waivers.—

(6) A service provider operating an addictions receiving facility or providing detoxification on a nonhospital inpatient basis may not exceed its licensed capacity by more than 10 percent and may not exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

Section 24. Paragraph (i) is added to subsection (1) of section 397.4073, Florida Statutes, to read:

397.4073 Background checks of service provider personnel.—

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.—

(i) A physician licensed under chapter 458 or chapter 459 or a nurse licensed under chapter 464 who was required to undergo background screening by the Department of Health as part of his or her initial licensure or the renewal of licensure, and who has an active and unencumbered license, is not subject to background screening pursuant to this section.

Section 25. Subsection (8) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(8) RIGHT TO COUNSEL.—Each individual must be informed that he or she has the right to be represented by counsel in any judicial ~~involuntary~~ proceeding for involuntary ~~assessment, stabilization, or~~ treatment services and that he or she, or if the individual is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

Section 26. Section 397.581, Florida Statutes, is amended to read:

397.581 Unlawful activities relating to assessment and treatment; penalties.—

(1) A person may not knowingly and willfully:

(a) Furnish ~~furnishing~~ false information for the purpose of obtaining emergency or other involuntary admission of another person ~~for any person is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000~~.

(b) ~~(2)~~ Cause or otherwise secure, or conspire with or assist another to cause or secure ~~Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired,~~ any emergency or other involuntary procedure of another ~~for the~~ person under false pretenses ~~is a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000~~.

(c) ~~(3)~~ Cause, or conspire with or assist another to cause, without lawful justification ~~Causing, or conspiring with or assisting another to cause~~, the denial to any person of any right accorded pursuant to this chapter.

(2) A person who violates subsection (1) commits ~~is~~ a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Section 27. Section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe that the person is substance abuse impaired or has a substance use disorder and a co-occurring mental health disorder and, because of such impairment or disorder:

(1) Has lost the power of self-control with respect to substance abuse; and

(2)(a) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard, although mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services; or

(b) Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services, or there is substantial likelihood

that the person has inflicted, or threatened to or attempted to inflict, or, unless admitted, is likely to inflict, physical harm on himself, herself, or another.

Section 28. Subsection (1) of section 397.6751, Florida Statutes, is amended to read:

397.6751 Service provider responsibilities regarding involuntary admissions.—

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the most appropriate and least restrictive available setting that is responsive to the person's treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

Section 29. Section 397.681, Florida Statutes, is amended to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.—

(1) JURISDICTION.—The courts have jurisdiction of ~~involuntary assessment and stabilization petitions and~~ involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person resides ~~is located~~. The clerk of the court may not charge a fee for the filing of a petition under this section. The chief judge may appoint a general or special magistrate to preside over all or part of the proceedings. The alleged impaired person is named as the respondent.

(2) RIGHT TO COUNSEL.— A respondent has the right to counsel at every stage of a judicial proceeding relating to a petition for his or her ~~involuntary assessment and a petition for his or her~~ involuntary treatment for substance abuse impairment, but the respondent may waive that right if the

respondent is present and the court finds that such waiver is made knowingly, intelligently, and voluntarily. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs or desires the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

Section 30. Section 397.693, Florida Statutes, is renumbered as 397.68111, Florida Statutes, and amended to read:

397.68111 ~~397.693~~ Involuntary treatment.—A person may be the subject of a petition for court-ordered involuntary treatment pursuant to this part~~,~~ if that person:

(1) Reasonably appears to meet ~~meets~~ the criteria for involuntary admission provided in s. 397.675; ~~and:~~

(2)~~(1)~~ Has been placed under protective custody pursuant to s. 397.677 within the previous 10 days;

(3)~~(2)~~ Has been subject to an emergency admission pursuant to s. 397.679 within the previous 10 days; or

(4)~~(3)~~ Has been assessed by a qualified professional within 30 ~~5~~ days~~;~~

~~(4) Has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days; or~~

~~(5) Has been subject to alternative involuntary admission pursuant to s. 397.6822 within the previous 12 days~~.

Section 31. Section 397.695, Florida Statutes, is renumbered as section 397.68112, Florida Statutes, and amended to read:

397.68112 ~~397.695~~ Involuntary services; persons who may petition.—

(1) If the respondent is an adult, a petition for involuntary treatment services may be filed by the respondent's spouse or legal guardian, any relative, a service provider, or an adult who has direct personal knowledge of the respondent's substance abuse impairment and his or her prior course of assessment and treatment.

(2) If the respondent is a minor, a petition for involuntary treatment services may be filed by a parent, legal guardian, or service provider.

(3) The court may prohibit, or a law enforcement agency may waive, any service of process fees if a petitioner is determined to be indigent.

Section 32. Section 397.6951, Florida Statutes, is renumbered as 397.68141, Florida Statutes, and amended to read:

397.68141 ~~397.6951~~ Contents of petition for involuntary

treatment services.—A petition for involuntary services must contain the name of the respondent; the name of the petitioner ~~or petitioners~~; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known; ~~the findings and recommendations of the assessment performed by the qualified professional;~~ and the factual allegations presented by the petitioner establishing the need for involuntary ~~outpatient~~ services for substance abuse impairment. The factual allegations must demonstrate:

(1) The reason for the petitioner's belief that the respondent is substance abuse impaired;

(2) The reason for the petitioner's belief that because of such impairment the respondent has lost the power of self-control with respect to substance abuse; and

(3)(a) The reason the petitioner believes that the respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless the court orders the involuntary services; or

(b) The reason the petitioner believes that the respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

(4) The petition may be accompanied by a certificate or report of a qualified professional who examined the respondent

within 30 days before the petition was filed. The certificate or report must include the qualified professional's findings relating to his or her assessment of the patient and his or her treatment recommendations. If the respondent was not assessed before the filing of a treatment petition or refused to submit to an evaluation, the lack of assessment or refusal must be noted in the petition.

(5) If there is an emergency, the petition must also describe the respondent's exigent circumstances and include a request for an ex parte assessment and stabilization order that must be executed pursuant to s. 397.68151.

Section 33. Section 397.6955, Florida Statutes, is renumbered as section 397.68151, Florida Statutes, and amended to read:

397.68151 ~~397.6955~~ Duties of court upon filing of petition for involuntary services.—

(1) Upon the filing of a petition for involuntary services for a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. If the court appoints counsel for the person, the clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel, created pursuant to s. 27.511, of the appointment. The office of criminal conflict and civil regional

counsel shall represent the person until the petition is dismissed, the court order expires, ~~or~~ the person is discharged from involuntary treatment services, or the office is otherwise discharged by the court. An attorney that represents the person named in the petition shall have access to the person, witnesses, and records relevant to the presentation of the person's case and shall represent the interests of the person, regardless of the source of payment to the attorney.

(2) The court shall schedule a hearing to be held on the petition within 10 court working ~~5~~ days unless a continuance is granted. The court may appoint a magistrate to preside at the hearing.

(3) A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct. If the respondent is a minor, a copy of the petition and notice of the hearing must be personally delivered to the respondent. The clerk ~~court~~ shall also issue a summons to the person whose admission is sought and unless a circuit court's chief judge authorizes disinterested private process servers to serve parties under this chapter, a law enforcement agency must effect such service on the person whose admission is sought for the initial treatment hearing.

Section 34. Section 397.6818, Florida Statutes, is amended to read:

397.6818 Court determination.—

(1) When the petitioner asserts that emergency circumstances exist, or when upon review of the petition the court determines that an emergency exists, the court may rely solely on the contents of the petition and, without the appointment of an attorney, enter an ex parte order for the respondent's involuntary assessment and stabilization which must be executed during the period when the hearing on the petition for treatment is pending.

(2) The court may further order a law enforcement officer or another designated agent of the court to:

(a) Take the respondent into custody and deliver him or her for evaluation to either the nearest appropriate licensed service provider or a licensed service provider designated by the court.

(b) Serve the respondent with the notice of hearing and a copy of the petition.

(3) The service provider may not hold the respondent for longer than 72 hours of observation, unless:

(a) The service provider seeks additional time under s. 397.6957(1)(c) and the court, after a hearing, grants that motion;

(b) The respondent shows signs of withdrawal, or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until the issue is resolved but no later than the scheduled hearing date, absent a court-approved extension; or

(c) The original or extended observation period ends on a weekend or holiday, including the hours before the ordinary business hours of the following workday morning, in which case the provider may hold the respondent until the next court working day.

(4) If the ex parte order was not executed by the initial hearing date, it shall be deemed void. However, should the respondent not appear at the hearing for any reason, including lack of service, and upon reviewing the petition, testimony, and evidence presented, the court reasonably believes the respondent meets this chapter's commitment criteria and that a substance abuse emergency exists, the court may issue or reissue an ex parte assessment and stabilization order that is valid for 90 days. If the respondent's location is known at the time of the hearing, the court:

(a) Shall continue the case for no more than 10 court working days; and

(b) May order a law enforcement officer or another designated agent of the court to:

1. Take the respondent into custody and deliver him or her for evaluation to either the nearest appropriate licensed service provider or a licensed service provider designated by the court; and

2. If a hearing date is set, serve the respondent with notice of the rescheduled hearing and a copy of the involuntary treatment petition if the respondent has not already been served.

Otherwise, the petitioner must inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as is practicable. However, if the respondent has not been assessed within 90 days, the court must dismiss the case. ~~At the hearing initiated in accordance with s. 397.6811(1), the court shall hear all relevant testimony. The respondent must be present unless the court has reason to believe that his or her presence is likely to be injurious to him or her, in which event the court shall appoint a guardian advocate to represent the respondent. The respondent has the right to examination by a court-appointed qualified professional. After hearing all the evidence, the court shall determine whether there is a reasonable basis to believe the respondent meets the involuntary admission criteria of s. 397.675.~~

~~(1) Based on its determination, the court shall either dismiss the petition or immediately enter an order authorizing the involuntary assessment and stabilization of the respondent; or, if in the course of the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to injure himself or herself or another if allowed to remain at liberty, the court may initiate involuntary proceedings under the provisions of part I of chapter 394.~~

~~(2) If the court enters an order authorizing involuntary assessment and stabilization, the order shall include the court's findings with respect to the availability and appropriateness of the least restrictive alternatives and the need for the appointment of an attorney to represent the respondent, and may designate the specific licensed service provider to perform the involuntary assessment and stabilization of the respondent. The respondent may choose the licensed service provider to deliver the involuntary assessment where possible and appropriate.~~

~~(3) If the court finds it necessary, it may order the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order or, if none is specified, to the nearest appropriate licensed service provider for involuntary assessment.~~

~~(4) The order is valid only for the period specified in the order or, if a period is not specified, for 7 days after the order is signed.~~

Section 35. Section 397.6957, Florida Statutes, is amended to read:

397.6957 Hearing on petition for involuntary treatment services.—

(1)(a) The respondent must be present at a hearing on a petition for involuntary treatment services~~,~~ unless the court finds that he or she knowingly, intelligently, and voluntarily waives his or her right to be present or, upon receiving proof of service and evaluating the circumstances of the case, that his or her presence is inconsistent with his or her best interests or is likely to be injurious to self or others. The court shall hear and review all relevant evidence, including testimony from individuals such as family members familiar with the respondent's prior history and how it relates to his or her current condition, and the ~~review of~~ results of the assessment completed by the qualified professional in connection with this chapter. The court may also order drug tests. Upon a finding of good cause, the court may permit all witnesses, including, but not limited to, medical professionals who are or have been involved with the respondent's treatment, to remotely attend and testify at the hearing under oath via audio-video teleconference. A witness intending to remotely attend and

testify must provide the parties with all relevant documents by the close of business on the day before the hearing ~~the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others, in which event the court must appoint a guardian advocate to act in behalf of the respondent throughout the proceedings~~.

(b) A respondent may not be involuntarily ordered into treatment under this chapter without a clinical assessment being performed, unless he or she is present in court and expressly waives the assessment. In nonemergency situations, if the respondent was not, or had previously refused to be, assessed by a qualified professional and, based on the petition, testimony, and evidence presented, it reasonably appears that the respondent qualifies for involuntary treatment services, the court shall issue an involuntary assessment and stabilization order to determine the appropriate level of treatment the respondent requires. Additionally, in cases where an assessment was attached to the petition, the respondent may request, or the court on its own motion may order, an independent assessment by a court-appointed or otherwise agreed upon qualified professional. If an assessment order is issued, it is valid for 90 days, and if the respondent is present or there is either

proof of service or his or her location is known, the involuntary treatment hearing shall be continued for no more than 10 court working days. Otherwise, the petitioner must inform the court that the respondent has been assessed so that the court may schedule a hearing as soon as is practicable. The assessment must occur before the new hearing date, and if there is evidence indicating that the respondent will not voluntarily appear at the forthcoming hearing or is a danger to self or others, the court may enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the date of the rescheduled hearing. However, if after 90 days the respondent remains unassessed, the court shall dismiss the case.

(c)1. The respondent's assessment by a qualified professional must occur within 72 hours after his or her arrival at a licensed service provider unless the respondent shows signs of withdrawal or a need to be either detoxified or treated for a medical condition, which shall extend the amount of time the respondent may be held for observation until such issue is resolved but no later than the scheduled hearing date, absent a court-approved extension. If the respondent is a minor, such assessment must be initiated within the first 12 hours of the minor's admission to the facility. The service provider may also move to extend the 72 hours of observation by petitioning the court in writing for additional time. The service provider must

furnish copies of such motion to all parties in accordance with applicable confidentiality requirements, and after a hearing, the court may grant additional time. If the court grants the service provider's petition, the service provider may continue to hold the respondent, and if the original or extended observation period ends on a weekend or holiday, including the hours before the ordinary business hours of the following workday morning, the provider may hold the respondent until the next court working day.

2. No later than the ordinary close of business on the day before the hearing, the qualified professional shall transmit, in accordance with any applicable confidentiality requirements, his or her clinical assessment to the clerk of the court, who shall enter it into the court file. The report must contain a recommendation on the level of substance abuse treatment the respondent requires, if any, and the relevant information on which the qualified professional's findings are based. This document must further note whether the respondent has any co-occurring mental health or other treatment needs. For adults subject to an involuntary assessment, the report's filing with the court satisfies s. 397.6758 if it also contains the respondent's admission and discharge information. The qualified professional's failure to include a treatment recommendation, much like a recommendation of no treatment, shall result in the petition's dismissal.

(2) The petitioner has the burden of proving by clear and convincing evidence that:

(a) The respondent is substance abuse impaired and has a history of lack of compliance with treatment for substance abuse; and

(b) Because of such impairment the respondent is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:

1. Without services, the respondent is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that there is a substantial likelihood that without services the respondent will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior; or

2. The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

(3) ~~One of the qualified professionals who executed the involuntary services certificate must be a witness. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law,~~

~~regarding the respondent's prior history and how that prior history relates to the person's current condition. The~~ Testimony in the hearing must be taken under oath, and the proceedings must be recorded. The respondent ~~patient~~ may refuse to testify at the hearing.

(4) If at any point during the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, meets the involuntary commitment provisions of part I of chapter 394, the court may initiate involuntary examination proceedings under such provisions.

(5)~~(4)~~ At the conclusion of the hearing the court shall either dismiss the petition or order the respondent to receive involuntary treatment services from his or her chosen licensed service provider if possible and appropriate. Any treatment order must include findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives.

Section 36. Section 397.697, Florida Statutes, is amended to read:

397.697 Court determination; effect of court order for involuntary services.—

(1)(a) When the court finds that the conditions for involuntary treatment services have been proved by clear and convincing evidence, it may order the respondent to receive

involuntary treatment services from a publicly funded licensed service provider for a period not to exceed 90 days. The court may also order a respondent to undergo treatment through a privately funded licensed service provider if the respondent has the ability to pay for the treatment, or if any person on the respondent's behalf voluntarily demonstrates a willingness and an ability to pay for the treatment. If the court finds it necessary, it may direct the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order, or to the nearest appropriate licensed service provider, for involuntary treatment services. When the conditions justifying involuntary treatment services no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment services are expected to exist after 90 days of treatment services, a renewal of the involuntary services order may be requested pursuant to s. 397.6975 before the end of the 90-day period.

(b) To qualify for involuntary outpatient treatment, an individual must be supported by a social worker or case manager of a licensed service provider, or a willing, able, and responsible individual appointed by the court who shall inform the court and parties if the respondent fails to comply with his or her outpatient program. In addition, unless the respondent has been involuntarily ordered into inpatient treatment under

this chapter at least twice during the last 36 months, or demonstrates the ability to substantially comply with the outpatient treatment while waiting for residential placement to become available, he or she must receive an assessment from a qualified professional or licensed physician expressly recommending outpatient services, such services must be available in the county in which the respondent is located, and it must appear likely that the respondent will follow a prescribed outpatient care plan.

(2) In all cases resulting in an order for involuntary treatment services, the court shall retain jurisdiction over the case and the parties for the entry of such further orders as the circumstances may require, including, but not limited to, monitoring compliance with treatment, changing the treatment modality, or initiating contempt of court proceedings for violating any valid order issued pursuant to this chapter. Hearings under this section may be set by motion of the parties or under the court's own authority, and the motion and notice of hearing for these ancillary proceedings, which include, but are not limited to, civil contempt, must be served in accordance with relevant court procedural rules. The court's requirements for notification of proposed release must be included in the original order.

(3) An involuntary treatment services order also authorizes the licensed service provider to require the

individual to receive treatment services that will benefit him or her, including treatment services at any licensable service component of a licensed service provider.

(4) If the court orders involuntary treatment services, a copy of the order must be sent to the managing entity within 1 working day after it is received from the court. Documents may be submitted electronically through ~~though~~ existing data systems, if applicable. The institute established under 1004.44, shall also receive and maintain copies of the involuntary assessment and treatment orders issued pursuant to ss. 397.68151, 397.6818 and 397.6957, the qualified professional assessments, the professional certificates, and the law enforcement officers' protective custody reports. The institute established under 1004.44, shall use such documents to prepare annual reports analyzing the data the documents contain, without including patients' personal identifying information, and the institute shall post such reports on its website and provide copies of the reports to the department, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year.

Section 37. Section 397.6971, Florida Statutes, is amended to read:

397.6971 Early release from involuntary services.—

(1) At any time before the end of the 90-day involuntary treatment services period, or before the end of any extension

granted pursuant to s. 397.6975, an individual receiving involuntary treatment services may be determined eligible for discharge to the most appropriate referral or disposition for the individual when any of the following apply:

(a) The individual no longer meets the criteria for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status.

(b) If the individual was admitted on the grounds of likelihood of infliction of physical harm upon himself or herself or others, such likelihood no longer exists.

(c) If the individual was admitted on the grounds of need for assessment and stabilization or treatment, accompanied by inability to make a determination respecting such need:

1. Such inability no longer exists; or

2. It is evident that further treatment will not bring about further significant improvements in the individual's condition.

(d) The individual ~~is~~ no longer needs treatment ~~in need of~~ services.

(e) The director of the service provider determines that the individual is beyond the safe management capabilities of the provider.

(2) Whenever a qualified professional determines that an individual admitted for involuntary treatment services qualifies for early release under subsection (1), the service provider

shall immediately discharge the individual and must notify all persons specified by the court in the original treatment order.

Section 38. Section 397.6975, Florida Statutes, is amended to read:

397.6975 Extension of involuntary treatment services period.—

(1) Whenever a service provider believes that an individual who is nearing the scheduled date of his or her release from involuntary treatment services continues to meet the criteria for involuntary services in s. 397.68111 or s. 397.6957 ~~s. 397.693~~, a petition for renewal of the involuntary treatment services order must ~~may~~ be filed with the court ~~at least 10 days~~ before the expiration of the court-ordered services period. The petition may be filed by the service provider or by the person who filed the petition for the initial treatment order if the petition is accompanied by supporting documentation from the service provider. The court shall immediately schedule a hearing within 10 court working days to be held not more than 15 days after filing of the petition and~~.~~ the court shall provide the copy of the petition for renewal and the notice of the hearing to all parties and counsel to the proceeding. The hearing is conducted pursuant to ss. 397.6957 and 397.697 and must be held before the circuit court unless referred to a magistrate ~~s. 397.6957~~.

(2) If the court finds that the petition for renewal of the involuntary treatment services order should be granted, it may order the respondent to receive involuntary treatment services for a period not to exceed an additional 90 days. When the conditions justifying involuntary treatment services no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary services continue to exist after an additional 90 days of service, a new petition requesting renewal of the involuntary treatment services order may be filed pursuant to this section.

~~(3) Within 1 court working day after the filing of a petition for continued involuntary services, the court shall appoint the office of criminal conflict and civil regional counsel to represent the respondent, unless the respondent is otherwise represented by counsel. The clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel of such appointment. The office of criminal conflict and civil regional counsel shall represent the respondent until the petition is dismissed or the court order expires or the respondent is discharged from involuntary services. Any attorney representing the respondent shall have access to the respondent, witnesses, and records relevant to the presentation of the respondent's case and shall represent the interests of the respondent, regardless of the source of payment to the attorney.~~

~~(4) Hearings on petitions for continued involuntary services shall be before the circuit court. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this section shall be in accordance with s. 397.697.~~

~~(5) Notice of hearing shall be provided to the respondent or his or her counsel. The respondent and the respondent's counsel may agree to a period of continued involuntary services without a court hearing.~~

~~(6) The same procedure shall be repeated before the expiration of each additional period of involuntary services.~~

~~(7) If the respondent has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the respondent's competence.~~

Section 39. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary services.—

(1) At the conclusion of the 90-day period of court-ordered involuntary services, the respondent is automatically discharged unless a motion for renewal of the involuntary services order has been filed with the court pursuant to s. 397.6975.

(2) Discharge planning and procedures for any respondent's release from involuntary treatment services must include and

document the respondent's needs, and actions to address such needs, for, at a minimum:

(a) Follow-up behavioral health appointments.

(b) Information on how to obtain prescribed medications.

(c) Information pertaining to available living arrangements and transportation.

(d) Referral to recovery support opportunities, including, but not limited to, connection to a peer specialist.

Section 40. Section 397.6811, Florida Statutes, is repealed.

Section 41. Section 397.6814, Florida Statutes, is repealed.

Section 42. Section 397.6815, Florida Statutes, is repealed.

Section 43. Section 397.6819, Florida Statutes, is repealed.

Section 44. Section 397.6821, Florida Statutes, is repealed.

Section 45. Section 397.6822, Florida Statutes, is repealed.

Section 46. Section 397.6978, Florida Statutes, is repealed.

Section 47. Subsection (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment under this chapter, may be committed to the department, and the department shall retain and treat the defendant.

(a) Immediately after receipt of a completed copy of the court commitment order containing all documentation required by the applicable Florida Rules of Criminal Procedure, the department shall request all medical information relating to the defendant from the jail. The jail shall provide the department with all medical information relating to the defendant within 3 business days after receipt of the department's request or at the time the defendant enters the physical custody of the department, whichever is earlier.

(b) Within 60 days after the date of admission and at the end of any period of extended commitment, or at any time the administrator or his or her designee determines that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

(c)1. If the department determines at any time that a defendant will not or is unlikely to regain competency to

proceed, the department shall, within 30 days after the determination, complete and submit a competency evaluation report to the circuit court to determine if the defendant meets the criteria for involuntary civil commitment under s. 394.467. A qualified professional, as defined in s. 394.455, must sign the competency evaluation report for the circuit court under penalty of perjury. A copy of the report shall be provided, at a minimum, to the court, state attorney, and counsel for the defendant before initiating any transfer of the defendant back to the committing jurisdiction.

2. For purposes of this paragraph, the term "competency evaluation report to the circuit court" means a report by the department regarding a defendant's incompetence to proceed in a criminal proceeding due to mental illness as set forth in this section. The report shall include, at a minimum, the following regarding the defendant:

a. A description of mental, emotional, and behavioral disturbances.

b. An explanation to support the opinion of incompetence to proceed.

c. The rationale to support why the defendant is unlikely to gain competence to proceed in the foreseeable future.

d. A clinical opinion regarding whether the defendant no longer meets the criteria for involuntary forensic commitment pursuant to this section.

e. A recommendation on whether the defendant meets the criteria for involuntary services pursuant to s. 394.467.

(d) ~~(c)~~ The defendant must be transported, in accordance with s. 916.107, to the committing court's jurisdiction within 7 days after ~~of~~ notification that the defendant is competent to proceed or no longer meets the criteria for continued commitment. A determination on the issue of competency must be made at a hearing within 30 days of the notification. If the defendant is receiving psychotropic medication at a mental health facility at the time he or she is discharged and transferred to the jail, the administering of such medication must continue unless the jail physician documents the need to change or discontinue it. To ensure continuity of care, the referring mental health facility must transfer the patient with up to 30 days of medications and assist in discharge planning with medical teams at the receiving county jail. The jail and department physicians shall collaborate to ensure that medication changes do not adversely affect the defendant's mental health status or his or her ability to continue with court proceedings; however, the final authority regarding the administering of medication to an inmate in jail rests with the jail physician. Notwithstanding this paragraph, a defendant who meets the criteria for involuntary examination pursuant to s. 394.463 as determined by an independent clinical opinion shall

appear remotely for the hearing. Court witnesses may appear remotely.

Section 48. Subsection (6) of section 40.29, Florida Statutes, is amended to read:

40.29 Payment of due-process costs; reimbursement for petitions and orders.—

(6) Subject to legislative appropriation, the clerk of the circuit court may, on a quarterly basis, submit to the Justice Administrative Commission a certified request for reimbursement for petitions and orders filed under ss. 394.459, 394.463, 394.467, and 394.917, ~~and 397.6814,~~ at the rate of $40 per petition or order. Such request for reimbursement shall be submitted in the form and manner prescribed by the Justice Administrative Commission pursuant to s. 28.35(2)(i).

Section 49. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455 ~~s. 394.455(49)~~.

Section 50. Paragraph (e) of subsection (4) of section 464.012, Florida Statutes, is amended to read:

464.012 Licensure of advanced practice registered nurses; fees; controlled substance prescribing.—

(4) In addition to the general functions specified in subsection (3), an advanced practice registered nurse may perform the following acts within his or her specialty:

(e) A psychiatric nurse, who meets the requirements in s. 394.455(37) ~~s. 394.455(36)~~, within the framework of an established protocol with a psychiatrist, may prescribe psychotropic controlled substances for the treatment of mental disorders.

Section 51. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455 ~~s. 394.455(49)~~, without an involuntary placement proceeding as provided by law.

Section 52. Subsection (3) of section 916.107, Florida Statutes, is amended to read:

916.107 Rights of forensic clients.—

(3) RIGHT TO EXPRESS AND INFORMED CONSENT.—

(a) A forensic client shall be asked to give express and informed written consent for treatment. If a client refuses such treatment as is deemed necessary and essential by the client's

multidisciplinary treatment team for the appropriate care of the client, such treatment may be provided under the following circumstances:

1. In an emergency situation in which there is immediate danger to the safety of the client or others, such treatment may be provided upon the ~~written~~ order of a physician for up to 48 hours, excluding weekends and legal holidays. If, after the 48-hour period, the client has not given express and informed consent to the treatment initially refused, the administrator or designee of the civil or forensic facility shall, within 48 hours, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of the client. In the interim, the need for treatment shall be reviewed every 48 hours and may be continued without the consent of the client upon the continued ~~written~~ order of a physician who has determined that the emergency situation continues to present a danger to the safety of the client or others.

2. In a situation other than an emergency situation, the administrator or designee of the facility shall petition the court for an order authorizing necessary and essential treatment for the client.

a. If the client has been receiving psychotropic medication at the jail at the time of transfer to the forensic or civil facility and lacks the capacity to make an informed decision regarding mental health treatment at the time of admission, the admitting physician shall order continued administration of psychotropic medication if, in the clinical judgment of the physician, abrupt cessation of that psychotropic medication could pose a risk to the health or safety of the client while a court order to medicate is pursued. The administrator or designee of the forensic or civil facility shall, within 5 days after a client's admission, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of a client with psychotropic medication. The jail physician shall provide a current psychotropic medication order at the time of transfer to the forensic or civil facility or upon request of the admitting physician after the client is evaluated.

b. The court order shall allow such treatment for up to 90 days after the date that the order was entered. Unless the court is notified in writing that the client has provided express and informed written consent or that the client has been discharged by the committing court, the administrator or designee of the facility shall, before the expiration of the initial 90-day

order, petition the court for an order authorizing the continuation of treatment for an additional 90 days. This procedure shall be repeated until the client provides consent or is discharged by the committing court.

3. At the hearing on the issue of whether the court should enter an order authorizing treatment for which a client was unable to or refused to give express and informed consent, the court shall determine by clear and convincing evidence that the client has mental illness, intellectual disability, or autism, that the treatment not consented to is essential to the care of the client, and that the treatment not consented to is not experimental and does not present an unreasonable risk of serious, hazardous, or irreversible side effects. In arriving at the substitute judgment decision, the court must consider at least the following factors:

a. The client's expressed preference regarding treatment;

b. The probability of adverse side effects;

c. The prognosis without treatment; and

d. The prognosis with treatment.

The hearing shall be as convenient to the client as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the client's condition. The court may appoint a general or special magistrate to preside at the hearing. The client or the client's guardian,

and the representative, shall be provided with a copy of the petition and the date, time, and location of the hearing. The client has the right to have an attorney represent him or her at the hearing, and, if the client is indigent, the court shall appoint the office of the public defender to represent the client at the hearing. The client may testify or not, as he or she chooses, and has the right to cross-examine witnesses and may present his or her own witnesses.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment or nonpsychiatric medical procedures, and prior to performing the procedure, written permission shall be obtained from the client, if the client is legally competent, from the parent or guardian of a minor client, or from the guardian of an incompetent client. The administrator or designee of the forensic facility or a designated representative may, with the concurrence of the client's attending physician, authorize emergency surgical or nonpsychiatric medical treatment if such treatment is deemed lifesaving or for a situation threatening serious bodily harm to the client and permission of the client or the client's guardian could not be obtained before provision of the needed treatment.

Section 53. For the 2024-2025 fiscal year, the sum of $50,000,000 of recurring funds from the General Revenue Fund are

provided to the Department of Children and Families to implement the provisions of this act.

Section 54. This act shall take effect July 1, 2024.

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

Remove everything before the enacting clause and insert:

An act relating to mental health and substance abuse; amending s. 394.455, F.S.; conforming a cross-reference to changes made by the act; amending s. 394.4572, F.S.; providing an exception to background screening requirements for certain licensed physicians and nurses; amending s. 394.459, F.S.; specifying a timeframe for recording restrictions in a patient's clinical file; requiring that such recorded restriction be immediately served on certain parties; conforming a provision to changes made by the act; amending s. 394.4598, F.S.; authorizing certain psychiatric nurses to consult with guardian advocates for purposes of obtaining consent for treatment; amending s. 394.4599, F.S.; revising written notice requirements relating to filing petitions for involuntary services; amending s. 394.461, F.S.; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's

case-in-chief; prohibiting the court from considering substantive information in the transfer evaluation; providing an exception; revising reporting requirements; amending s. 394.4615, F.S.; allowing a patient’s legal custodian to authorize release of the patient’s clinical records; conforming provisions to changes made by the act; amending s. 394.462, F.S.; authorizing a county to include alternative funding arrangements for transporting individuals to designated receiving facilities in the county’s transportation plan; conforming provisions to changes made by the act; amending s. 394.4625, F.S.; revising requirements relating to voluntary admissions to a facility for examination and treatment; requiring certain treating psychiatric nurses to document specified information in a patient's clinical record within a specified timeframe of his or her voluntary admission for mental health treatment; requiring clinical psychologists who make determinations of involuntary placement at certain mental health facilities to have specified clinical experience; authorizing certain psychiatric nurses to order emergency treatment for certain patients; conforming provisions to changes made by the act; amending s. 394.463, F.S.; authorizing, rather than requiring, law

enforcement officers to take certain persons into custody for involuntary examinations; requiring a law enforcement officer to provide a parent or legal guardian of a minor being transported to certain facilities with specified facility information; providing an exception; requiring written reports by law enforcement officers to contain certain information;; requiring a certain institute to collect and analyze certain documents and use them to prepare annual reports; providing requirements for such reports; requiring the institute to post such reports on its website; providing a due date for the annual reports; requiring the department to post a specified report on its website; revising requirements for releasing a patient from a receiving facility; revising requirements for petitions for involuntary services; requiring the department and the Agency for Health Care Administration to analyze certain data, identify patterns and trends, and make recommendations to decrease avoidable admissions; authorizing recommendations to be addressed in a specified manner; requiring the department to publish a specified report on its website and submit such report to the Governor and Legislature by a certain date; amending s. 394.4655, F.S.; defining the term "involuntary

outpatient placement"; authorizing a specified court to order an individual to involuntary outpatient treatment; removing provisions relating to criteria, retention of a patient, and petition for involuntary outpatient services and court proceedings relating to involuntary outpatient services; amending s. 394.467, F.S.; providing definitions; revising requirements for ordering a person for involuntary services and treatment, petitions for involuntary service, appointment of counsel, and continuances of hearings, respectively; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary services; authorizing certain psychiatric nurses to recommend involuntary services for mental health treatment; revising the conditions under which a court may waive the requirement for a patient to be present at an involuntary inpatient placement hearing; authorizing the court to permit witnesses to attend and testify remotely at the hearing through specified means; providing requirements for a witness to attend and testify remotely; requiring facilities to make certain clinical records available to a state attorney within a specified timeframe; specifying that such records remain confidential and may not be used for certain purposes; requiring the court to allow certain

testimony from specified persons; revising the length of time a court may require a patient to receive services; requiring facilities to discharge patients when they no longer meet the criteria for involuntary inpatient treatment; prohibiting courts from ordering individuals with developmental disabilities to be involuntarily placed in a state treatment facility; requiring courts to refer such individuals, and authorizing courts to refer certain other individuals, to specified agencies for evaluation and services; providing requirements for service plan modifications, noncompliance with involuntary outpatient services, and discharge, respectively; revising requirements for the procedure for continued involuntary services and return to facilities, respectively; amending s. 394.468, F.S.; revising requirements for discharge planning and procedures; providing requirements for the discharge transition process; creating s. 394.4915, F.S.; establishing the Office of Children's Behavioral Health Ombudsman within the Department of Children and Families for a specified purpose; providing responsibilities of the office; requiring the department and managing entities to include specified information in a specified manner on their websites; amending ss. 394.495 and 394.496, F.S.;

conforming provisions to changes made by the act; amending s. 394.499, F.S.; revising eligibility requirements for children's crisis stabilization unit/juvenile addictions receiving facility services; amending s. 394.875, F.S.; removing a limitation on the size of a crisis stabilization unit; removing a requirement for the department to implement a certain demonstration project; amending s. 394.9085, F.S.; conforming a cross-reference to changes made by the act; amending s. 397.305, F.S.; revising the purpose to include the most appropriate environment for substance abuse services; amending s. 397.311, F.S.; revising definitions; amending s. 397.401, F.S.; prohibiting certain service providers from exceeding their licensed capacity by more than a specified percentage or for more than a specified number of days; amending s. 397.4073, F.S.; providing an exception to background screening requirements for certain licensed physicians and nurses; amending s. 397.501, F.S.; revising notice requirements for the right to counsel; amending s. 397.581, F.S.; revising actions that constitute unlawful activities relating to assessment and treatment; providing penalties; amending s. 397.675, F.S.; revising the criteria for involuntary admissions for purposes of assessment and

stabilization, and for involuntary treatment; amending s. 397.6751, F.S.; revising service provider responsibilities relating to involuntary admissions; amending s. 397.681, F.S.; revising where involuntary treatment petitions for substance abuse impaired persons may be filed; specifying requirements for the court to allow a waiver of the respondent's right to counsel relating to petitions for involuntary treatment; revising the circumstances under which courts are required to appoint counsel for respondents without regard to respondents' wishes; renumbering and amending s. 397.693, F.S.; revising the circumstances under which a person may be the subject of court-ordered involuntary treatment; renumbering and amending s. 397.695, F.S.; authorizing the court or clerk of the court to waive or prohibit any service of process fees for petitioners determined to be indigent; renumbering and amending s. 397.6951, F.S.; revising the information required to be included in a petition for involuntary treatment services; authorizing a petitioner to include a certificate or report of a qualified professional with such petition; requiring such certificate or report to contain certain information; requiring that certain additional information be included if an emergency exists;

renumbering and amending s. 397.6955, F.S.; revising when the office of criminal conflict and civil regional counsel represents a person in the filing of a petition for involuntary services and when a hearing must be held on such petition; requiring a law enforcement agency to effect service for initial treatment hearings; providing an exception; amending s. 397.6818, F.S.; authorizing the court to take certain actions and issue certain orders regarding a respondent's involuntary assessment if emergency circumstances exist; providing a specified timeframe for taking such actions; amending s. 397.6957, F.S.; expanding the exemption from the requirement that a respondent be present at a hearing on a petition for involuntary treatment services; authorizing the court to order drug tests and to permit witnesses to attend and testify remotely at the hearing through certain means; removing a provision requiring the court to appoint a guardian advocate under certain circumstances; prohibiting a respondent from being involuntarily ordered into treatment unless certain requirements are met; providing requirements relating to involuntary assessment and stabilization orders; providing requirements relating to involuntary treatment hearings; requiring that the assessment of a

respondent occur before a specified time unless certain requirements are met; authorizing service providers to petition the court in writing for an extension of the observation period; providing service requirements for such petitions; authorizing the service provider to continue to hold the respondent if the court grants the petition; requiring a qualified professional to transmit his or her report to the clerk of the court within a specified timeframe; requiring the clerk of the court to enter the report into the court file; providing requirements for the report; providing that the report's filing satisfies the requirements for release of certain individuals if it contains admission and discharge information; providing for the petition's dismissal under certain circumstances; authorizing the court to order certain persons to take a respondent into custody and transport him or her to or from certain service providers and the court; revising the petitioner's burden of proof in the hearing; authorizing the court to initiate involuntary proceedings and have the respondent evaluated by the Agency for Persons with Disabilities under certain circumstances; requiring that, if a treatment order is issued, it must include certain findings; amending s. 397.697, F.S.; requiring

that an individual meet certain requirements to qualify for involuntary outpatient treatment; revising the jurisdiction of the court with respect to certain orders entered in a case; specifying that certain hearings may be set by either the motion of a party or under the court's own authority; requiring a certain institute to receive and maintain copies of certain documents and use them to prepare annual reports; providing requirements for such reports; requiring the institute to post such reports on its website; amending s. 397.6971, F.S.; conforming provisions to changes made by the act; amending s. 397.6975, F.S.; authorizing certain entities to file a petition for renewal of an involuntary treatment services order; revising the timeframe during which the court is required to schedule a hearing; amending s. 397.6977, F.S.; providing requirements for discharge planning and procedures for a respondent's release from involuntary treatment services; repealing ss. 397.6811, 397.6814, 397.6815, 397.6819, 397.6821, 397.6822, and 397.6978, F.S., relating to involuntary assessment and stabilization and the appointment of guardian advocates, respectively; amending s. 916.13, F.S.; requiring the Department of Children and Families to complete and submit a competency

evaluation report to the circuit court to determine if a defendant adjudicated incompetent to proceed meets the criteria for involuntary civil commitment if it is determined that the defendant will not or is unlikely to regain competency; defining the term "competency evaluation report to the circuit court"; requiring a qualified professional to sign such report under penalty of perjury; providing requirements for such report; authorizing a defendant who meets the criteria for involuntary examination and court witnesses to appear remotely for a hearing; amending ss. 40.29, 409.972, 464.012, 744.2007, and 916.107,F.S.; conforming provisions to changes made by the act; providing an appropriation; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: Pub. Rec. & Meetings HB 7041 PCB SHI 24-01 Public Records and Meetings Exemptions
SPONSOR(S): Select Committee on Health Innovation, Andrade
TIED BILLS: HB 1549 **IDEN./SIM. BILLS:** SB 322

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on Health Innovation	11 Y, 0 N	McElroy	Calamas
1) Ethics, Elections & Open Government Subcommittee	17 Y, 0 N	Rando	Toliver
2) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

HB 1549, to which this bill is linked, requires Florida to join the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact and the Physical Therapy Licensure Compact.

Each of these compacts require compact member states to share certain licensure and personal identifying information concerning physicians, speech-language pathologists, audiologists, and physical therapists authorized to practice under their respective compact. The compacts further require that certain meetings be closed to the public.

The bill creates a public record exemption for certain licensure and personal identifying information, other than the name, licensure information, or licensure number, for providers authorized to practice under each compact, obtained from the data system and held by the Department of Health (DOH) or the applicable board from public record requirements, unless the laws of the state that originally reported the information authorizes disclosure.

The bill creates a public meeting exemption to allow the commission of each compact to convene in a closed meeting if the meeting is held to discuss certain specified matters. The bill also creates a public meeting exemption for commission meetings of each compact, or portions of such meetings, at which matters exempt from public disclosure by federal or state law are discussed. The bill provides that any recordings, minutes, and records generated from such a meeting, or portions of such meeting, are also exempt from public record requirements.

The bill provides that the public record and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless saved from repeal through reenactment by the Legislature.

This bill may have a, negative, but likely insignificant, fiscal impact on DOH and other boards, and no fiscal impact on local governments.

The bill will become effective on the same date that HB 1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates public record and public meeting exemptions; thus, it requires a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Open Government

The Florida Constitution sets forth the state's public policy regarding access to government records and meetings. Every person is guaranteed a right to inspect or copy any public record of the legislative, executive, and judicial branches of government.[1] All meetings of any collegial public body of the executive branch of state government or any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, must be open and noticed to the public.[2] The Legislature, however, may provide by general law an exemption[3] from public record or meeting requirements provided that the exemption passes by a two-thirds vote of each chamber, states with specificity the public necessity justifying the exemption, and is no broader than necessary to meet its public purpose.[4]

Pursuant to the Open Government Sunset Review Act,[5] a new public record or meeting exemption or substantial amendment of an existing exemption is repealed on October 2nd of the fifth year following enactment, unless the Legislature reenacts the exemption.[6]

Public Records

Current law also addresses the public policy regarding access to government records, guaranteeing every person a right to inspect and copy any state, county, or municipal record, unless the record is exempt.[7] Furthermore, the Open Government Sunset Review Act provides that a public record exemption may be created, revised, or maintained only if it serves an identifiable public purpose and the "Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption."[8] An identifiable public purpose is served if the exemption meets one of the following purposes:

- Allow the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protect sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only the identity of an individual may be exempted under this provision; or
- Protect trade or business secrets.[9]

Public Meetings

Current law also addresses public policy regarding access to government meetings, further requiring all meetings of any board or commission of any state agency or authority, or of any agency or authority of any county, municipality, or political subdivision, at which official acts are to be taken to be open to the public at all times, unless the meeting is exempt.[10] The board or commission must provide reasonable

[1] Art. I, s. 24(a), FLA. CONST.
[2] Art. I, s. 24(b), FLA. CONST.
[3] A public record exemption means a provision of general law which provides that a specified record or meeting, or portion thereof, is not subject to the access requirements of s. 119.07(1), F.S., s. 286.011, F.S., or s. 24, Art. I of the Florida Constitution. *See* s. 119.011(8), F.S.
[4] Art. I, s. 24(c), FLA. CONST.
[5] Section 119.15, F.S.
[6] Section 119.15(3), F.S.
[7] *See* s. 119.01, F.S.
[8] Section 119.15(6)(b), F.S.
[9] *Id.*
[10] Section 286.011(1), F.S.

notice of all public meetings.[11] Public meetings may not be held at any location that discriminates on the basis of sex, age, race, creed, color, origin, or economic status or that operates in a manner that unreasonably restricts the public's access to the facility.[12] Minutes of a public meeting must be promptly recorded and open to public inspection.[13] Failure to abide by public meeting requirements will invalidate any resolution, rule, or formal action adopted at a meeting.[14] A public officer or member of a governmental entity who violates public meeting requirements is subject to civil and criminal penalties.[15]

Health Care Licensure Compacts

HB 1549, to which this bill is linked, requires Florida to join the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact. The compacts were created to facilitate multistate practice of licensed physicians, speech-language pathologists, audiologists, and physical therapists.

Under their respective compact, an eligible licensed physician, speech-language pathologist, audiologist, physical therapist or a physical therapist assistant is authorized to practice within the scope of his or her license in all compact member states. Each health care provider practicing under this compact privilege must comply with the practice laws of the state in which he or she is providing service or where the patient is located.

Under each compact, member states are also required to report certain licensure information on licensees in compact member states to a shared data system, including identifying information, licensure data, and any adverse actions taken against the health care providers license or compact privilege. Investigative information pertaining to a licensee in any compact member state must be available to other member states. Compact member states may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.

Under each compact, HB 1549 requires Florida to share information that is not currently exempt from public record requirements under s. 119.07(1), F.S., and s. 24(a), Art. I of the Florida Constitution.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (Medical Compact) requires states to share licensee information for all licensed physicians, or physicians who have applied for licensure, to a coordinated data system. Information that will be shared that is not currently exempt from public record requirements under s. 119.07(1), F.S., and s. 24(a), Art. I of the Florida Constitution, includes:

- Identifying information;
- Licensure data;
- Public action taken against a licensed physician who has applied for or received an expedited license through the compact; and
- Public and confidential complaint, disciplinary, or investigatory information.

Audiology and Speech-Language Pathology Compact

The Audiology and Speech-Language Pathology Compact (ASLP Compact) requires member states to report the following licensure information and other non-exempt information for all licensed audiologists and speech-language pathologists practicing under the ASLP Compact:

- Identifying information;

[11] *Id.*
[12] Section 286.011(6), F.S.
[13] Section 286.011(2), F.S.
[14] Section 286.011(1), F.S.
[15] Section 286.011(3), F.S.

- Licensure data;
- Adverse actions against the audiologist's or speech-language pathologist's license;
- Nonconfidential information related to participation in alternative programs;
- Any licensure application denials and reasons for such denial; and
- Other information, determined by commission rule, which may facilitate the administration of the compact.

Physical Therapy Licensure Compact

The Physical Therapy Licensure Compact (PT Compact) requires each member state to report the following licensure information and other non-exempt information for all licensed physical therapists and physical therapist assistants practicing under the compact:

- Identifying information;
- Licensure data;
- Investigative information;
- Adverse actions against the physical therapists or physical therapist assistant's license or compact privilege;
- Any licensure application denials and reasons for such denial; and
- Other information, determined by commission rule, which may facilitate the administration of the compact.

Commission Meetings

The Medical Compact, ASLP Compact, and the PT Compact each require their respective compact commission to conduct meetings. The commission meetings must be open to the public, and public notice must be given. However, for the discussion of certain specified topics, each compact requires the commission to conduct a closed meeting. To close a public meeting in Florida, a specific exemption from public meeting requirements under s. 24(b), Art. I of the Florida Constitution and s. 286.011, F.S., is required. Current law does not provide a public meeting exemption for commission meetings.

The effective date of the bill is the same date that HB 1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session, or an extension thereof and becomes law.

Effect of the Bill

The bill makes personal identifying information, other than the name, licensure status, or licensure number, of a physician, speech-language pathologist, audiologist, or physical therapist authorized to practice under their respective compact, obtained from the coordinated data system and held by the DOH or the applicable board exempt from public record requirements, unless the laws of the state that originally reported the information authorizes disclosure. Disclosure under such circumstance is limited to the extent permitted under the laws of the reporting state.

The bill also creates a public meeting exemption for commission meetings of each compact, or portions of such meetings, where matters exempt from public disclosure by federal or state law are discussed. Recordings, minutes, and records generated during an exempt portion of a commission meeting are also exempt from public disclosure.

The bill provides statements of public necessity for the public record exemptions, as required by the Florida Constitution, and states that the protection of such information is required under the Medical Compact, ASLP Compact, and the PT Compact, which the state must adopt in order to become a party state to each compact. Without the public record exemptions, the state would be unable to effectively and efficiently implement and administer the compacts.

Additionally, the bill provides a statement of public necessity for the public meeting exemption, as

required by the Florida Constitution, and states that the compacts require any meeting where matters exempt from public disclosure by federal or state law are discussed to be closed to the public. Without the public meeting exemption, the state will be prohibited from becoming a party to the compacts and would be unable to effectively and efficiently administer the compacts. The bill further provides that it is a public necessity for the recordings, minutes, and records generated during an exempt meeting be made exempt, as the release of such information would negate the public meeting exemption.

The bill provides that the public record and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless saved from repeal through reenactment by the Legislature.

The effective date of the bill is the same date that HB 1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law, which is July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 456.4503, F.S., relating to Interstate Medical Licensure Compact Commission; public records and meetings exemption.
Section 2: Creates s. 468.1336, F.S., relating to Audiology and Speech-language Pathology; public records and meetings exemption.
Section 3: Creates s. 486.113, F.S., relating to Physical Therapy Licensure Compact Commission; public records and meetings exemption.
Section 4: Provides statements of public necessity as required by the Florida Constitution.
Section 5: Provides that the bill is effective on the same date as HB 1549 (2024) or similar legislation takes effect.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have a negative, but likely insignificant, fiscal impact on DOH and applicable boards because staff responsible for complying with public record requests may require training related to the implementation of the new public record exemption. The costs, however, would likely be absorbed as they are part of the day-to-day responsibilities of agencies.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

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:

Vote Requirement
Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates public record and public meeting exemptions; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement
Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates public record and public meeting exemptions; thus, it includes statements of public necessity. The statements of public necessity provide that the Legislature finds, in part, that the protection of the exempt information and closure of certain meetings are required under each compact, and without the exemptions, the state would be unable to effectively and efficiently implement and administer the compacts.

Breadth of Exemption
Article I, s. 24(c) of the Florida Constitution provides that an exemption must be created by general law and the law must contain only exemptions from public record or public meeting requirements. The exemption does not appear to be in conflict with the constitutional requirement.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rule-making or rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to public records and meetings exemptions; creating ss. 456.4503, 468.1336, and 486.113, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health, the Board of Speech-Language Pathology and Audiology, and the Board of Physical Therapy Practice pursuant to the Interstate Medical Licensure Compact, the Audiology and Speech-language Pathology Interstate Compact, and the Physical Therapy Licensure Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meetings requirements for certain meetings of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-language Pathology Interstate Compact Commission, and the Physical Therapy Licensure Compact Commission; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such meetings; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing contingent effective dates.

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

Section 1. Section 456.4503, Florida Statutes, is created to read:

456.4503 Interstate Medical Licensure Compact Commission; public records and meetings exemptions.—

(1) A physician's personal identifying information, other than the physician's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in Section 8 of s. 456.4501 and held by the department is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Interstate Medical Licensure Compact Commission established in Section 11 of s. 456.4501 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed

on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. Section 468.1336, Florida Statutes, is created to read:

468.1336 Audiology and Speech-language Pathology Interstate Compact Commission; public meetings and public records exemptions.—

(1) An audiologist's or a speech-language pathologist's personal identifying information, other than the audiologist's or the speech-language pathologist's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in article IX of s. 468.1335 and held by the department or the board is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Audiology and Speech-language Pathology Interstate Compact Commission established in article VIII of s. 468.1335 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 3. Section 486.113, Florida Statutes, is created to read:

486.113 Physical Therapy Licensure Compact Commission; public records and meetings exemptions.—

(1) A physical therapist's personal identifying information, other than the physical therapist's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in article VIII of s. 486.112 and held by the department or the board is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Physical Therapy Compact Commission or the executive board or any other committee of the commission established in article VII of s.

486.112 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 4. (1) The Legislature finds that it is a public necessity that a physician's, an audiologist's or a speech-language pathologist's, and a physical therapist's personal identifying information, other than the person's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in Section 8 of s. 456.4501, Florida Statutes, article IX of s. 468.1335, Florida Statutes, and article VIII of s. 486.112, Florida Statutes, and held by the Department of Health, the Board of Speech-Language Pathology and Audiology, and the Board of Physical Therapy Practice be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Interstate Medical Licensure Compact, the Audiology and Speech-language Pathology Interstate Compact, and the Physical Therapy Licensure Compact,

each of which the state must adopt in order to become a member state of the respective compact. Without the public records exemption, the state would be unable to effectively and efficiently implement and administer the respective compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-language Pathology Interstate Compact Commission, or the Physical Therapy Licensure Compact Commission held as provided in s. 456.4501, Florida Statutes, s. 468.1335, Florida Statutes, or s. 486.112, Florida Statutes, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution.

(b) The Interstate Medical Licensure Compact, the Audiology and Speech-language Pathology Interstate Compact, and the Physical Therapy Licensure Compact require any meeting, or any portion of a meeting, of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-language Pathology Interstate Compact Commission, and the Physical Therapy Licensure Compact Commission in which the substance of paragraph (a) is discussed to be closed to the public. In the absence of a public meetings exemption, the state would be prohibited from becoming a member state of the respective compact and, thus, prohibited from effectively and efficiently administering the

respective compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 456.4503(2), Florida Statutes, s. 468.1336(2), Florida Statutes, or s. 486.113(2), Florida Statutes, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meetings exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 5. This act shall take effect on the same date that HB 1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

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 & Human Services Committee

Representative Andrade offered the following:

Amendment

Remove lines 87-113 and insert:

(1) A physical therapist's or physical therapist assistant’s personal identifying information, other than the physical therapist's or physical therapist assistant’s name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in article VIII of s. 486.112 and held by the department or the board is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If

disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Physical Therapy Compact Commission or the executive board or any other committee of the commission established in article VII of s. 486.112 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 4. (1) The Legislature finds that it is a public necessity that a physician's, an audiologist's or a speech-language pathologist's, and a physical therapist's or physical therapist assistant’s personal