Health Care Appropriations Subcommittee

Tuesday, January 30, 2018
1:00 p.m. - 3:00 p.m.
Sumner Hall (404 HOB)

MEETING PACKET

REVISED

Richard Corcoran
Speaker

Jason Brodeur
Chair

The Florida House of Representatives
Appropriations Committee
Health Care Appropriations Subcommittee

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Speaker

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Agenda
Tuesday, January 30, 2018
1:00 p.m. – 3:00 p.m.
Sumner Hall (404 HOB)

I. **Call to Order/Roll Call**

II. **Opening Remarks**

III. **Consideration of the following bill(s):**

- CS/HB 259 Elder Abuse Fatality Review Teams by Children, Families & Seniors Subcommittee, Watson, B.
- CS/HB 679 Telepharmacy by Health Quality Subcommittee, Ponder
- CS/HB 751 Public Assistance by Children, Families & Seniors Subcommittee, Eagle

IV. **Closing Remarks/Adjournment**

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 259 Elder Abuse Fatality Review Teams
SPONSOR(S): Children, Families & Seniors Subcommittee; Watson
TIED BILLS: HB 261 **IDEN./SIM. BILLS:** SB 422

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	10 Y, 0 N, As CS	Gilani	Brazzell
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida has the highest percentage of senior residents in the nation, projected to increase from 20 to 25 percent (5.9 million seniors) by 2030. Mental and physical infirmities of aging and social isolation make elders vulnerable to abuse, which increases their rates of hospitalization and hastens death. One in 10 elders is abused, but incidents of elder abuse are reported in less than 5 percent of cases, primarily because the most common perpetrator is a relative, friend, neighbor, or caregiver whom the elder trusts or fears.

The Department of Children and Families (DCF) is responsible for the state's adult protective investigations. DCF investigates reports of elder abuse, including elder deaths, and facilitates supportive services to victims. In FY 2016-17, DCF received 41,192 reports of elder abuse, neglect, or exploitation and investigated 181 deaths in which the death was allegedly due to abuse or neglect.

Florida has programs to systematically review deaths due to child abuse or domestic violence. Different than protective investigations, these fatality review teams are generally established to understand the causes and incidents of deaths, identify any gaps in support and service delivery, and improve preventive interventions.

The bill creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review closed cases where the death of an elderly person was alleged or found to have been caused by, or related to, abuse or neglect. EA-FRTs are housed in the Department of Elder Affairs (DOEA) for administrative purposes only. Participation in EA-FRT is voluntary and team members shall serve without compensation.

The bill includes procedures for organization and creation of an EA-FRT, appointment of EA-FRT members, and obtaining relevant records for an EA-FRT. In its review, an EA-FRT shall consider the surrounding circumstances and events leading up to a fatal incident, identify any gaps in support and service delivery, and make recommendations for systemic improvements to prevent elder abuse and deaths.

The bill requires each EA-FRT to submit an annual report on its findings to DOEA by September 1 and DOEA to submit a summary report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and DCF by November 1 each year.

The bill prevents records held by an EA-FRT from being subject to discovery or introduced into evidence in any proceeding, with exceptions. The bill prohibits the testimony of EA-FRT members or participants in any proceeding, with exceptions. The bill grants EA-FRT members immunity from monetary liability and prohibits a cause of action in certain circumstances, with exceptions.

The bill amends s. 415.107(3), F.S., and authorizes DCF to release confidential and exempt adult protective investigative records to DOEA if they pertain to the death of an elderly person under review by an EA-FRT.

The bill will have an indeterminate, but likely insignificant negative fiscal impact on state government that can be absorbed within existing resources.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

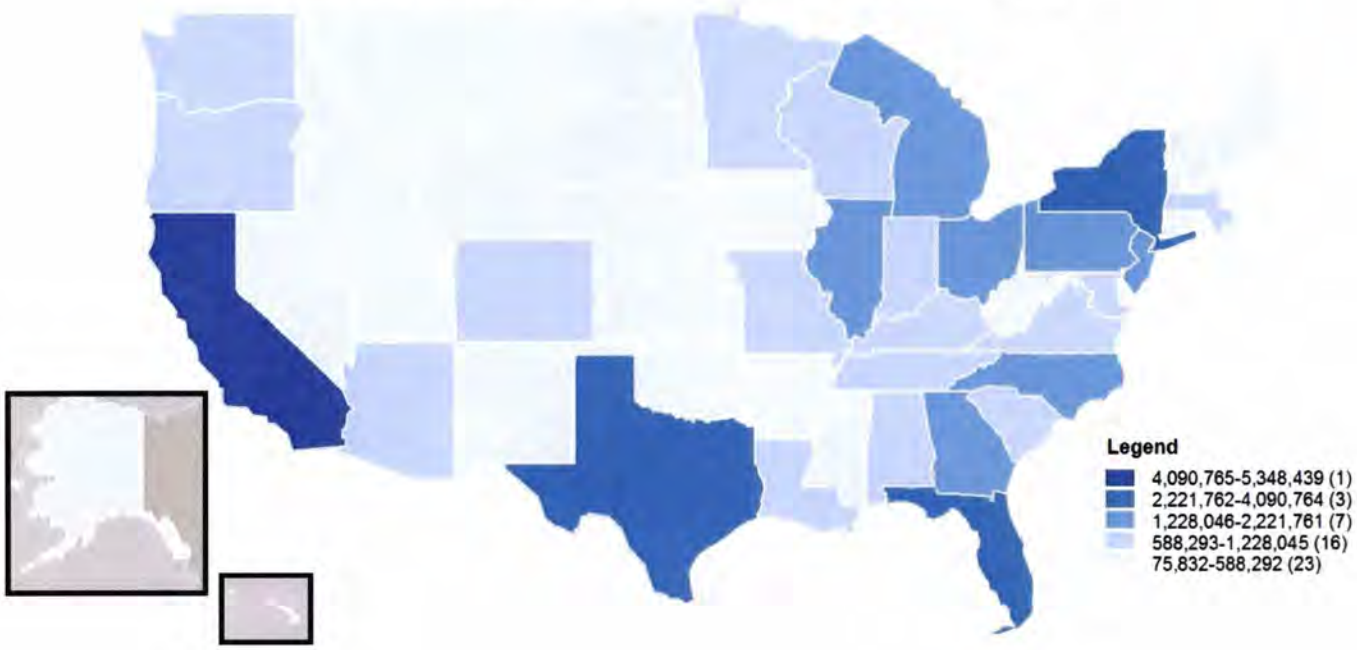
I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation:

As the country's "baby-boomer" population reaches retirement age and life expectancy increases, the nation's elder population is projected to increase from 49.2 million in 2016[1] to 72.8 million by 2030.[2] Florida has long been a destination state for senior citizens and has the highest percentage of senior residents in the entire nation.[3] In 2016, Florida had an estimated 4.1 million people aged 65 and older, approximately 20 percent of the state's population.[4] By 2030, this number is projected to increase to 5.9 million, meaning the elderly will make up approximately one quarter of the state's population and will account for most of the state's growth.[5,6,7]

National Distribution of Population Ages 65 and Older (2016)[8]



[1] Press Release, U.S. CENSUS BUREAU, *The Nation's Older Population is Still Growing, Census Bureau Reports* (June 22, 2017), Release Number: CB17-100, *available at*: https://www.census.gov/newsroom/press-releases/2017/cb17-100.html (last visited Jan. 3, 2018).
[2] U.S. CENSUS BUREAU, *2012 National Population Projections, Middle Series*, p.44, available at: https://www2.census.gov/programs-surveys/popproj/technical-documentation/methodology/methodstatement12.pdf (last visited Nov. 21, 2017).
[3] *Where Do the Oldest Americans Live?*, PEW RESEARCH CENTER, July 9, 2015, available at: http://www.pewresearch.org/fact-tank/2015/07/09/where-do-the-oldest-americans-live/ (last visited Nov. 18, 2017).
[4] U.S. CENSUS BUREAU, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited Jan. 3, 2018).
[5] FLORIDA OFFICE OF ECONOMIC & DEMOGRAPHIC RESEARCH, *Population Data: 2016, 2020, 2025, 2030, 2035, 2040, & 2045, County by Age, Race, Sex, and Hispanic Origin*, pp. 89-90, available at: http://edr.state.fl.us/Content/population-demographics/data/Medium_Projections_ARSH.pdf (last visited Nov. 10, 2017).
[6] FLORIDA OFFICE OF ECONOMIC & DEMOGRAPHIC RESEARCH, *Econographic News: Economic and Demographic News for Decision Makers, 2017, Vol. 1*, available at: http://edr.state.fl.us/Content/population-demographics/reports/econographicnews-2017v1.pdf (last visited Nov. 10, 2017).
[7] *Supra* note 5, at 269-70.
[8] Map made with the U.S. Census Bureau's interactive data mapping tools using population estimation data from 2016.

Elder populations are vulnerable to abuse and exploitation due to risk factors associated with aging, such as physical and mental infirmities and social isolation.[9,10] In Florida, almost one million senior citizens are medically underserved and 1.6 million suffer from one or more disabilities.[11] According to the Department of Justice, approximately 1 in 10 seniors is abused each year in the United States, and incidents of elder abuse are reported to local authorities in 1 out of every 23 cases.[12] Elder abuse can have significant physical and emotional effects on an older adult, and can lead to premature death.[13] Abused seniors are twice as likely to be hospitalized and three times more likely to die than non-abused seniors.[14]

Elder abuse occurs in community settings, such as private homes, as well as in institutional settings like nursing homes and other long-term care facilities. Prevalent forms of abuse are financial exploitation, neglect, emotional or psychological abuse, and physical abuse; however, an elder abuse victim will often experience multiple forms of abuse at the same time.[15] The most common perpetrators of elder abuse are relatives, such as adult children or a spouse, followed by friends and neighbors, and then home care aides.[16] Research shows that elder abuse is underreported, often because the victims fear retribution or care for or trust their perpetrators.[17] Elder abuse deaths are more likely to go undetected because an elder death is expected to occur, given age or infirmity, more so than other deaths due to abuse such as a child death or a death involving domestic violence.[18] Experts believe this may be one of the reasons elder abuse lags behind child abuse and domestic violence in research, awareness, and systemic change.[19]

Florida's Adult Protective Services System

Chapter 415, F.S., creates Florida's Adult Protective Services (APS) under the Department of Children and Families (DCF). DCF protects vulnerable adults,[20] including elders, from abuse, neglect, and exploitation through mandatory reporting and investigation of suspected abuse.[21] This includes deaths allegedly due to abuse, neglect, and exploitation.[22] In FY 2016-17, DCF received 41,192 reports of abuse, neglect, or exploitation of persons aged 60 years or older and investigated 181 deaths in which

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[9] NATIONAL CENTER ON ELDER ABUSE, *What are the Risk Factors?*, https://ncea.acl.gov/whatwedo/research/statistics.html#risk (last visited Jan. 4, 2018).
[10] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA INTERN MED. 173:10 at 911-917 (2013).
[11] DEPARTMENT OF ELDER AFFAIRS, *2016 Profile of Elder Floridians,* available at: http://elderaffairs.state.fl.us/doea/pubs/stats/County_2016_projections/Counties/Florida.pdf (last visited Nov. 24, 2017).
[12] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, available at: https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Ron Acierno et al., *Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study*, 100:2 AM. J. PUB. HEALTH, at 292-297 (Feb. 2010), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/ (last visited Jan. 3, 2018).
[13] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Mark S. Lachs et al., *The Mortality of Elder Mistreatment*, 280:5 JAMA at 428-432 (1998), available at: https://jamanetwork.com/journals/jama/fullarticle/187817 (last visited Jan. 4, 2018).
[14] U.S. DEPARTMENT OF JUSTICE, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Nov. 19, 2017). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA INTERN MED. 173:10 at 911-917 (2013).
[15] NATIONAL CENTER ON ELDER ABUSE, *Challenges in Elder Abuse Research,* available at: https://ncea.acl.gov/whatwedo/research/statistics.html#challenges (last visited Jan. 4, 2018).
[16] NATIONAL CENTER ON ELDER ABUSE, *Who are the Perpetrators?*, https://ncea.acl.gov/whatwedo/research/statistics.html#perpetrators (last visited Jan. 4, 2018).
[17] CENTER FOR DISEASE CONTROL AND PREVENTION, *Understanding Elder Abuse, Fact Sheet 2016*, available at: https://www.cdc.gov/violenceprevention/pdf/em-factsheet-a.pdf (last visited Jan. 4, 2018).
[18] U.S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE, *Elder Justice Roundtable Report: Medical Forensic Issues Concerning Abuse and Neglect*, October 18, 2000, p. 8, available at: https://www.ncjrs.gov/pdffiles1/nij/242221.pdf (last visited Jan. 4, 2018).
[19] Id. at pp. 7-10.
[20] A vulnerable adult is a person 18 years of age or older whose ability to perform normal activities of daily living or to provide for his or her own care or protection is impaired due to mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging, s. 415.102(28), F.S.
[21] S. 415.101(2), F.S.
[22] DEPARTMENT OF CHILDREN AND FAMILIES, *CF Operating Procedure No. 140-2: Adult Protective Services* (June 1, 2017), pp. 4-9 - 4-10, available at: http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Jan. 4, 2018).

the death was allegedly due to abuse or neglect.[23] During that same fiscal year, DCF verified 5,423 allegations of abuse or neglect, 27 of which involved a fatality.[24] Eighty-three (83) percent of these reports were from in-home settings, which is consistent with the research findings that relatives, friends, or caregivers are the main perpetrators of elder abuse.

DCF's Adult Investigations Involving Victims Age 60+ FYs 2012-2017[25]

FY	Reports Received [1]	Unique Reports [2]	# Verified	Deaths Reported/ Investigated [3]	# Verified	In-Home	Institutional
2016-2017	41,192	39,005	5,423	181	27	82.77%	17.23%
2015-2016	42,609	39,998	5,639	178	21	82.91%	17.09%
2014-2015	39,639	37,381	5,371	236	40	82.52%	17.48%
2013-2014	36,926	34,922	3,934	197	27	83.96%	16.04%
2012-2013	33,833	32,092	3,309	153	17	83.14%	16.86%

[1] *Reports received* ***counts Initial and Additional intakes accepted by the Hotline. There may be more than one call/reporter on the same incident.***

[2] *Unique reports* ***represents a unique count of intakes received. Multiple intakes on the same incident are not counted.***

[3] ***All reports accepted by the Hotline are investigated.***

Mandatory Reporting to the Central Abuse Hotline

DCF maintains a statewide 24/7 toll-free central abuse hotline where anyone can report known or suspected abuse, neglect, or exploitation.[26] This includes, but is not limited to, vulnerable adults. Any person that knows or has reasonable cause to suspect abuse, neglect, or exploitation of a vulnerable adult is required to immediately report this knowledge or suspicion to the central abuse hotline.[27] The hotline number must be provided to clients in nursing homes[28] and publicly displayed in every health facility licensed by the Agency for Health Care Administration (AHCA).[29] The number is also listed on the agency websites for DCF, AHCA, and the Department of Elder Affairs (DOEA).[30,31,32]

Additionally, any person who is required to investigate allegations of abuse, neglect, or exploitation, and who has reasonable cause to suspect that a vulnerable adult died as result of such harm must report that suspicion to DCF, the medical examiner, and appropriate criminal justice agency.[33] Medical examiners in turn are required to consider this information in their cause of death determinations and report their findings to DCF and the appropriate criminal justice agency and state attorney.[34]

Protective Investigations

Once DCF believes there is reasonable cause to suspect abuse or neglect of a vulnerable adult, they begin an investigation within 24 hours, to be conducted in cooperation with law enforcement and the state attorney.[35] DCF investigators determine, among other things, whether the vulnerable adult is in need of services, whether there is evidence of abuse, neglect or exploitation, the nature and extent of

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[23] Email from Lindsey Perkins Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Adult Protective Services Statistics (Nov. 29, 2017) (On file with House Health and Human Services Committee staff).
[24] Id.
[25] Id.
[26] S. 415.103, F.S.
[27] S. 415.1034(1), F.S.
[28] S. 408.810, F.S.
[29] S. 400.141, F.S.; AHCA poster can be found here: https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/docs/Nursing_Homes/Posters/NURSING_HOME_POSTER_ENGLISH_LETTER.pdf (last visited Nov. 10, 2017).
[30] DEPARTMENT OF CHILDREN AND FAMILIES, *Report Abuse Neglect or Exploitation*, http://www.myflfamilies.com/service-programs/abuse-hotline/report-online (last visited Nov. 10, 2017).
[31] AGENCY FOR HEALTH CARE ADMINISTRATION, *Complaint Administration Unit*, http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml (last visited Nov. 10, 2017).
[32] DEPARTMENT OF ELDER AFFAIRS, *Report Elder Abuse*, http://elderaffairs.state.fl.us/doea/report_abuse.php (last visited Nov. 10, 2017).
[33] S. 415.1034(2), F.S.
[34] S. 415.1034(2), F.S.
[35] S. 415.104(1), F.S. Note, DCF does not investigate reports of elder abuse when the adult victim is determined *not* to be vulnerable under s. 415.102(28), F.S. Those elder abuse cases are the sole jurisdiction of law enforcement agencies.

any harm, and what is necessary to ensure the victim's safety and well-being.[36] DCF investigators must complete their investigations and submit their recommendations within 60 days of the initial report.[37] If DCF determines that a victim is in need of protective services or supervision, it will provide or facilitate the provision of those services to the victim.[38] If a victim dies during an open investigation, DCF investigators must verify the cause of death before closing the case to determine if the death was related to abuse or neglect.[39]

If there is a report that a death occurred due to elder abuse, neglect, or exploitation, the DCF investigator notifies the department's Registered Nurse Specialist (RNS)[40] staffing his or her region within 24 hours. If the alleged victim resided with other vulnerable adults, DCF conducts an on-site investigation to ensure the safety of these individuals as well.[41]

The DCF investigator and RNS work together to gather all relevant medical investigative information, including but not limited to medical records, the death certificate, the autopsy report, and specific questions to be included in the investigative process.[42] The DCF investigators also gather other relevant information such as copies of any related law enforcement investigations, criminal history and abuse reports relating to the alleged perpetrator, and prior adult protective services records relating to the victim or perpetrator, including the facilities where the death occurred.[43]

The DCF investigators review all of this information before making their determinations as to the cause of death and will summarize their findings in a report.[44] In these cases involving an elder abuse death, DCF designates a second party to review the DCF investigators' findings before closing the case.[45] The second party reviews the investigation process to ensure that it was thorough and that all issues were properly addressed; reviews the reports for completeness and accuracy; and documents its review for DCF's records.[46]

Adult Protection Teams

DCF is also permitted to create multidisciplinary Adult Protection Teams in each district[47] to support activities of the protective services program and provide services the team finds necessary for victims of elder abuse.[48,49] The teams can only provide these services with the consent of the vulnerable adult, the person's guardian, or court order, and should not duplicate services provided by other units or offices of DCF.[50]

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[36] S. 415.104(3), F.S.
[37] S. 415.104(4), F.S.
[38] S. 415.105(1), F.S.
[39] DEPARTMENT OF CHILDREN AND FAMILIES, *CF Operating Procedure No. 140-2: Adult Protective Services* (June 1, 2017), p. 15-2, available at: http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Jan. 4, 2018).
[40] An RNS is a Florida-licensed registered nurse who assists the DCF in its APS investigations by providing medical expertise to help inform the DCF's findings, DEPARTMENT OF CHILDREN AND FAMILIES, *CF Operating Procedure No. 140-11: Adult Protective Services Registered Nurse Sepcialist* (Oct. 21, 2011), p. 1, available at: https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-11,%20Adult%20Protective%20Services%20Registered%20Nurse%20Specialist.pdf (last visited Jan. 4, 2018).
[41] *Supra* note 39, at 21-1.
[42] *Supra* note 39, at 21-2.
[43] Id.
[44] *Supra* note 39, at 21-2 - 21-3
[45] *Supra* note 39, at 21-3.
[46] Id.
[47] DCF has now adopted a regional structure rather than a district-based structure.
[48] S. 415.1102(1), 415.1102(4), F.S.
[49] DCF has established 15 Adult Protection Teams statewide, varying in how often and under what circumstances they convene, Email from Lindsey Perkins Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Adult Protective Services Statistics (Jan. 5, 2018) (On file with House Health and Human Services Committee staff).
[50] S. 415.1102(4), 415.1102(5), F.S.

The teams can consist of anyone trained in the prevention, identification, and treatment of abuse of elderly persons, such as:

- Psychiatrists, psychologists, other trained counseling personnel;
- Police officers or other law enforcement officers;
- Medical personnel who have sufficient training to provide health services;
- Social workers who have experience or training in preventing the abuse of elderly or dependent persons; or
- Public and professional guardians under part II of chapter 744, F.S.[51]

Comparable Fatality Review Systems

Children and victims of domestic violence are individuals who are vulnerable to death by abuse. Experts believe that the current state of elder abuse research is comparable to where research on child abuse and domestic violence was a few decades ago.[52] This is in large part due to the fact that elder abuse is underreported, more undetected, and suspected less than child abuse or domestic violence.[53] Florida has programs to systematically review deaths due to child abuse or domestic violence. Different than protective investigations, these fatality review teams are generally established to understand the causes and incidents of deaths, identify any gaps in support and service delivery, and improve preventive interventions.

Florida's Child Abuse Death Review

The Child Abuse Death Review (CADR) is a statewide multidisciplinary, multiagency child abuse death assessment and prevention system.[54] The state CADR committee is housed within the Department of Health and the State Surgeon General establishes county or multicounty local CADR committees. The Surgeon General appoints membership for both state and local CADR committees.[55] State and local teams work cooperatively to review the facts and circumstances surrounding child deaths that are reported through DCF's central abuse hotline.

The purpose of the CADR system is to:

- Achieve a greater understanding of the causes and contributing factors of child abuse deaths; [56]
- Develop a communitywide approach to addressing these contributing factors; [57]
- Identify gaps and deficiencies in the system of child abuse services; and [58]
- Make and implement recommendations for changes in law, rules, and policies to support healthy development of children and reduce preventable child abuse deaths.[59]

The state CADR committee consists of a representative from each of the following:

- The Department of Health;
- The Department of Children and Families;
- The Department of Law Enforcement;
- The Department of Education;
- The Florida Prosecuting Attorneys Association, Inc.; and
- The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.[60]

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[51] S. 415.1102(1), 415.1102(2), F.S.
[52] *Supra* note 18, at 7-10.
[53] Id.
[54] S. 383.402(1), F.S.
[55] S. 383.402(2), 383.402(3), F.S.
[56] S. 383.402(1)(a), F.S.
[57] S. 383.402(1)(b), F.S.
[58] S. 383.402(1)(c), F.S.
[59] S. 383.402(1)(d), F.S.
[60] S. 383.402(2)(a)1., F.S.

Participating entities may also recommend the addition of representatives from various disciplines that work to diagnose, treat, and prevent child abuse.[61]

Local CADR committees consist of, at a minimum, representatives from each of the following:

- The state attorney's office;
- The medical examiner's office;
- The local Department of Children and Families child protective investigations unit;
- The Department of Health child protection team;
- The community-based care lead agency;
- State, county, or local law enforcement agencies;
- The school district;
- A mental health treatment provider;
- A certified domestic violence center;
- A substance abuse treatment provider; and
- Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.[62]

CADR committees are granted access to all information and records from any state agency or political subdivision so long as the information may assist in reviewing a child's death.[63] Local committees review individual facts and circumstances of a child's death and provide the state review committee with demographic data, any gaps or deficiencies identified in the system, and recommendations for improvement.[64] The state review committee provides direction for the review system and analyzes the data and recommendations received from local review committees.[65] The state committee then submits a comprehensive annual report to the Governor and Legislature by December 1 each year.[66]

In the last fiscal year, all 22 local CADR committees used collected data to develop prevention action plans, including 194 activities designed to prevent child abuse.[67] Because drowning and asphyxia were the top causes of death in the previous year's data review, action plans included media campaigns, education, and training for safe sleep and water safety.[68] Similarly, because there is significant overlap between child maltreatment and domestic violence, substance abuse, and mental health, some action plans also addressed improvements in and increased access to parenting education, domestic violence advocates, and mental health treatment.[69]

Florida's Domestic Violence Fatality Review Teams

The state's Domestic Violence Fatality Review Teams (DV-FRT) are multidisciplinary teams that review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides.[70] DV-FRTs can be established at the local, regional, or state level.[71] Currently, there are 24 local DV-FRTs and one statewide team.[72] The DV-FRTs are assigned to the Florida Coalition against Domestic Violence for administrative purposes only, so the structure and activities of a team are determined at the local level.[73]

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[61] S. 383.402(2)(a)2., F.S.
[62] S. 383.402(3)(a), F.S.
[63] S. 383.402(5), F.S.
[64] S. 383.402(3)(b), F.S.
[65] S. 383.402(2)(b), F.S.
[66] S. 383.402(4), F.S.
[67] DEPARTMENT OF HEALTH, *State Child Abuse Death Review Committee Annual Report December 2017*, p. 51, available at: http://www.flcadr.com/reports/_documents/Final_CADR_2017.pdf (last visited Jan. 4, 2018).
[68] Id.
[69] Id.
[70] S. 741.316(1), F.S.
[71] S. 741.316(2), F.S.
[72] FLORIDA COALITION AGAINST DOMESTIC VIOLENCE, *The Attorney General's Statewide Domestic Violence Fatality Review Team,* https://www.fcadv.org/projects-programs/attorney-general%E2%80%99s-statewide-domestic-violence-fatality-review-team#_ftn1 (last visited Nov. 19, 2017).
[73] S. 741.316(5), 741.316(2), F.S.

The DV-FRTs include, but are not limited to, representatives from the following agencies or organizations:

- Law enforcement agencies;
- The state attorney's office;
- The medical examiner's office;
- Certified domestic violence centers;
- Child protection service providers;
- The office of the court administration;
- The clerk of the court;
- Victim services programs;
- Child death review teams;
- Members of the business community;
- County probation or corrections agencies; and
- Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence or suicide, including research, policy, law or other related matters.[74]

The DV-FRTs review events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and parties, and any information or action deemed relevant by the team.[75] The teams' purpose is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence.[76] Each team determines the number and type of incidents it will review and makes policy and other recommendations as to how incidents of domestic violence may be prevented.[77]

The Office of the Attorney General and the Florida Coalition against Domestic Violence co-chair the statewide DV-FRT, which meets quarterly to review data collected by the local teams, identify systemic gaps, and summarize its findings and recommendations for changes to the service delivery system in an annual report.[78]

Initiatives developed based on the reviews include:

- Since in 50 percent of cases reviewed, perpetrators had a prior history of domestic violence, substance abuse, or violent crimes, the statewide team developed a pilot project to train and increase coordination between local law enforcement agencies, prosecutors, judges, probation officers, and domestic violence advocates.[79,80] The purpose of this cooperation was to identify risk factors sooner, protect the victims, and prevent fatalities.[81]
- Discovering that 70 percent of victims had surviving children--some of whom even witnessed the fatal incident--the statewide team identified the need for and promoted collaboration with community partners to protect and provide services to the surviving children.[82]

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[74] S. 741.316(1), F.S.
[75] S. 741.316(2), F.S.
[76] S. 741.316(2), F.S.
[77] S. 741.316(2), F.S.
[78] *Supra* note 72.
[79] FLORIDA COALITION AGAINST DOMESTIC VIOLENCE, *Faces of Fatality, Vol. VII: Report of the Attorney General's Statewide Domestic Violence Fatality Review Team* (June 2017), p. 21, *available at:* http://fcadv.org/sites/default/files/face_fatality_vii.pdf (last visited Jan. 4, 2018).
[80] FLORIDA COALITION AGAINST DOMESTIC VIOLENCE, *Faces of Fatality, Vol. VI: Report of the Attorney General's Statewide Domestic Violence Fatality Review Team* (June 2016), pp. 6-8, *available at:* http://fcadv.org/sites/default/files/FACES%20OF%20FATALITY%20VI.pdf (last visited Jan. 4, 2018).
[81] Id.
[82] *Supra* note 79.

Elder Fatality Review Teams in other States

Currently, at least 15 jurisdictions have elder fatality review teams at the state or local level.[83] For example, California, another state with a large senior population, statutorily authorized local elder fatality review teams in 2003 and now has an elder fatality review team in over 30 of its 58 counties.[84]

One of the first multidisciplinary elder fatality review teams was created in 1999, in Sacramento County, California. After years of reviewing cases, the review team noted that a common pattern of abuse involved a relative caregiver's inability to cope with the responsibility of caring for an elder whose health and mobility were rapidly deteriorating. In response, the review team created a resource guide for elder caregivers and independent elders alike, including contact information for agencies that can help with financial issues, transportation, conservatorship, home repair, medical issues, mental health issues, and other important needs.[85] Pharmacies, senior centers, medical clinics, religious centers, and other senior organizations distributed the brochure.[86]

The team also facilitated cooperation between disciplines to provide comprehensive vital services to elders in one location.[87] Acting on the review team's recommendations, the local coroner's office and adult protective services launched a project to improve communication between both agencies, the local district attorney's office implemented training and education on elder issues, and the local sheriff's department launched a volunteer program in its elder abuse unit to better detect and investigate financial fraud cases. The review team also established an interdisciplinary team of adult protective services staff and medical staff to provide intensive case management services, which has resulted in a 49 to 69 percent reduction in emergency room visits for participating elders.[88]

Soon after its inception, an elder fatality review team in Ingham County, Michigan, including police, prosecutors, adult protective services, the medical examiner, and emergency personnel, identified elder abuse in a death that law enforcement had deemed ordinary: through this multidisciplinary approach, the team determined that the elder's state caregiver had administered a lethal dose of morphine. These findings facilitated the prosecution and conviction of the perpetrator.[89]

American Bar Association's Elder Abuse Fatality Review Team Manual

In 2001, the federal Department of Justice commissioned the American Bar Association Commission on Law and Aging (ABA-COLA) to identify promising practices in the development of elder abuse fatality review teams. The ABA-COLA studied pilot programs from 8 local and state jurisdictions.[90] The ABA-COLA then created a replication manual based on these 8 programs.[91]

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[83] NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION, *The State of Elder Fatality Reviews in the U.S.* (Webinar), available at: http://www.napsa-now.org/wp-content/uploads/2017/03/03142017-EFRT-Webinar.pdf (last visited on Nov. 19, 2017).
[84] THE NATIONAL LONG-TERM CARE OMBUDSMAN RESOURCE CENTER, *Long-Term Care Ombudsman Activities Regarding Abuse, Neglect and Exploitation*, May 10, 2011, available at: http://ltcombudsman.org/uploads/files/issues/Chart-Summary-SLTCO-FINAL-May-10.pdf (last visited Nov. 19, 2017).
[85] SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE, *County of Sacramento Elder Death Review Team 2012 Report*, p. 5, available at: http://www.sacda.org/files/7414/2671/1371/2012_EDRT_Annual_Report.pdf (last visited Jan. 4, 2018).
[86] SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE, *County of Sacramento Elder Death Review Team 2008 Report*, p. 5, available at: http://www.sacda.org/files/5514/2671/1055/2008_EDRT_Report_Final.pdf (last visited Jan. 4, 2018).
[87] SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE, *County of Sacramento Elder Death Review Team 2015 Report*, p. 2-3, available at http://www.sacda.org/files/9914/2671/1266/EDRT_2015_Report_FINAL.pdf (last visited Jan. 4, 2018).
[88] *Supra* note 86.
[89] Chisun Lee, A.C. Thompson, and Carl Byker, *Gone Without a Case: Suspicious Elder Deaths Rarely Investigated*, FRONTLINE PBS, https://www.pbs.org/wgbh/frontline/article/gone-without-a-case-suspicious-elder-deaths-rarely-investigated/ (last visited Jan. 4, 2018).
[90] Houston, Texas; Maine; Orange County, California; Pima County, Arizona; Pulaski County, Arkansas; Sacramento, California' San Diego, California; and San Francisco, California.
[91] Lori A. Stiegel, J.D., *Elder Abuse Fatality Review Teams: A Replication Manual*, AMERICAN BAR ASSOCIATION COMMISSION ON LAW & AGING, available at: https://www.americanbar.org/content/dam/aba/administrative/law_aging/fatalitymanual.authcheckdam.pdf (last visited Jan. 4, 2018).

The manual cites important factors for a successful review team: subject matter expertise and influence of membership, access to relevant records, confidentiality of review team meetings and records, and purpose and structure for the review process.

Pilot programs were generally to:

- To improve the systems that caused, contributed to, or failed to prevent the death, and thereby ensure that services are provided to elder abuse victims to help to prevent similar deaths in the future; or
- To determine whether law enforcement investigation and prosecution of alleged perpetrators is appropriate, and supporting those efforts.

The manual recommends that review teams include representatives from agencies or organizations that can provide insight into the systems and issues affecting elders, elder abuse, and elder fatalities, such as Adult Protective Services, the Attorney General's Office, elder lawyers, forensic pathologists, medical examiners, geriatricians, health providers, or victim assistance programs.

On the premise that lack of awareness may lead investigators and other professionals to miss signs of abuse and neglect in cases where abuse truly is present, the manual recommends broadening the scope of eligible cases to include fatalities where a history of elder abuse existed or elder abuse was suspected to be a contributing factor, even if not verified to be the cause of death.

The pilot programs studied by the ABA generally required legislative authorization to access the otherwise confidential records that were necessary for effective review of their cases. Similarly, confidentiality of review meetings and records allowed for open communication and rapport between members.

On October 20, 2017, the Department of Justice announced more than $3.42 million in funding to respond to elder abuse and victims of financial crimes, which included funding to the ABA-COLA to enhance and evaluate elder abuse fatality review teams.[92]

Effect of the Bill:

Elder Abuse Fatality Review Teams

The bill creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review elderly persons' deaths alleged or found to have been caused by, or related to, abuse or neglect. The teams are housed in the Department of Elder Affairs (DOEA) for administrative purposes only.

Membership and Organization

An EA-FRT may include, but is not limited to, representatives from public and private entities that study, treat, investigate, or prevent elder abuse, including but not limited to law enforcement agencies, health and social services agencies, healthcare practitioners, and nonprofit organizations.[93] Participation in an EA-FRT is voluntary and members serve without compensation or reimbursement for per diem or travel

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[92] Press Release, DEPARTMENT OF JUSTICE, *Justice Department Invests $3.42 Million in Fight Against Elder Abuse and Financial Exploitation* (Oct. 20, 2017), available at: https://www.justice.gov/opa/pr/justice-department-invests-342-million-fight-against-elder-abuse-and-financial-exploitation (last visited Jan. 4, 2018).

[93] Specifically: law enforcement agencies; the state attorney; the medical examiner; a county court judge; Adult Protective Services; the Aging and Disability Resource Center; the State Long-Term Care Ombudsman Program; the Agency for Health Care Administration; the Office of the Attorney General; the Office of the State Courts Administrator; the clerk of the court; a victim services program; an elder law attorney; emergency services personnel; a certified domestic violence center; an advocacy organization for victims of sexual violence; a funeral home director; a forensic pathologist; a geriatrician; a geriatric nurse; a geriatric psychiatrist or other individual licensed to offer behavioral health services; a hospital discharge planner; a public guardian; and/or other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence, including knowledge of research, policy, law, and other matters connected with such incidents or who are recommended for inclusion by the review team.

expenses. Members or the entities whom they represent bear the administrative costs of operating the EA-FRT.

Any person eligible to participate in an EA-FRT may initiate its establishment in his or her judicial circuit by requesting DOEA to call the first organizational meeting of the team. The Secretary of DOEA, or his or her designee, appoints the team members in consultation with the relevant public and private entities. Members serve for staggered two-year terms and may be reappointed for up to three consecutive terms. At an initial EA-FRT meeting, members choose two members to serve as co-chairs and may reelect them by a majority vote for up to two consecutive terms.

After its initial meeting, EA-FRTs determine their local operations, including the process for case selection and meeting schedule; however, EA-FRTs must limit their review to closed cases and meet at least once in each fiscal year.

Review Process

An EA-FRT's review includes consideration of the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by public and private systems and individuals related to the fatal incident.

In its review, an EA-FRT must identify any gaps, deficiencies, or problems in the delivery of services that related to the fatal incident. Whenever possible, an EA-FRT should develop a communitywide approach to address these causes and contributing factors identified in its review. Lastly, an EA-FRT must develop practice standards and recommend changes in law, rules, and policies to support the care of elderly persons and prevent elder abuse deaths.

Records

An EA-FRT may access information that is publicly available or voluntarily provided by a victim's family. Additionally, a team may ask DOEA to obtain the following records on its behalf:

- Information and records held by a criminal justice agency, not including active criminal intelligence or investigative information;[94]
- Information and records from DCF's adult protective investigations;[95] and
- An autopsy report from the medical examiner's office, not including photos and videos or audio recordings of the autopsy.[96]

The bill prohibits an EA-FRT or its members from disclosing any information that is confidential pursuant to law.

Annual Reports

Each EA-FRT team must prepare an annual report which includes, but is not limited to:

- Descriptive statistics of cases reviewed, including demographic information of the victims and caregivers, and the causes and nature of deaths;
- Current policies, procedures, rules, or statutes that the review team identified as contributing to the incidence of elder abuse and elder deaths, and recommendations for system improvement and needed resources, training, or information dissemination to address those identified issues;
- Any other recommendations to prevent elder abuse deaths based on an analysis of the data and information presented in the report; and

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[94] Records from criminal justice agencies are public. However, active criminal intelligence and active criminal investigative information are confidential and exempt pursuant to s. 119.011(3), F.S.

[95] DCF adult protective investigation records are confidential and exempt. Section 2 of this bill amends s. 415.107(3), to grant an EA-FRT access to these records.

[96] Autopsies are public records. However, s. 406.135 makes confidential and exempt any photographs or video or audio recording of an autopsy held by the medical examiner's office.

- Any steps the review team or private or public entities took to implement necessary changes and improve the coordination of services and reviews.

Each EA-FRT must submit this report to DOEA by September 1 each year. DOEA will summarize all of these reports into one final report and submit it to the Governor, the President of the Senate, the Speaker of the House of Representatives, and DCF by November 1 each year.

Discovery, Testimony, and Immunity

The bill prevents information or records obtained by an EA-FRT from being subject to discovery or introduced into evidence in any civil, criminal, administrative, or disciplinary proceeding. However, if information or records are available from another source and are not otherwise immune from discovery or introduction into evidence, then this immunity does not apply to those records or information simply because an EA-FRT obtained or reviewed them.

Similarly, the bill prohibits a person who has attended an EA-FRT meeting or participated in EA-FRT activities from testifying in any civil, criminal, administrative, or disciplinary proceeding as to records or information produced or presented to an EA-FRT in the course of its duties. However, this does not prevent any EA-FRT member or meeting attendee from testifying as to matters that are otherwise within his or her knowledge.

The bill provides EA-FRT members with immunity from monetary liability and prohibits a cause of action against them for matters that were in the performance of their duties as an EA-FRT member. However, this immunity will not apply if the member acted in bad faith, with wanton and willful disregard of human rights, safety, or property.

Access to DCF Adult Protective Investigation Records

The bill amends s. 415.107(3), F.S., to narrow the public records exemption for records and reports created by DCF's adult protective investigations. The bill authorizes DCF to release to DOEA records related to the death of an elderly person under review by an EA-FRT.

B. SECTION DIRECTORY:

Section 1: Creates s. 415.1103, F.S., relating to elder abuse fatality review teams.
Section 2: Amends s. 415.107(3), F.S., relating to the confidentiality of reports.
Section 3: Provides for an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

The bill creates an indeterminate negative fiscal impact on agencies and organizations that participate in an EA-FRT. However, such participation is voluntary.

The bill creates an indeterminate negative fiscal impact on the Department of Elder Affairs (DOEA). The bill requires DOEA to organize initial EA-FRT meetings, appoint members, obtain records on behalf of an EA-FRT, and prepare an annual summary report. If any EA-FRTs are established, DOEA staff responsibilities would increase, with the level of increase depending on the number of EA-FRTs established and their degree of activity. Additionally, DOEA may need to develop a secure method to transmit confidential and exempt records to an EA-FRT. Without knowing how many teams will be established, the amount of records DOEA will have to obtain, and whether any technology would need to be developed, the fiscal impact to DOEA is indeterminate, but likely insignificant and can be absorbed within existing resources.

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:

A tied bill, HB 261, makes certain records held or created by elder fatality review teams confidential and exempt. It also allows a team to close portions of its meetings wherein the members discuss confidential or exempt information or reveal the identity of an elder abuse victim.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to elder abuse fatality review teams; creating s. 415.1103, F.S.; authorizing the creation of elder abuse fatality review teams in each judicial circuit; housing the teams in the Department of Elderly Affairs for administrative purposes only; specifying membership; providing conditions for team establishment and organization; providing duties; providing teams with access to and use of records; requiring annual reports; providing immunity for members under certain conditions; exempting certain information and records from discovery; prohibiting a member from testifying about information or records presented during meetings or activities of the team; providing immunity from monetary liability for members under certain conditions; prohibiting team members from disclosing information confidential pursuant to law; amending s. 415.107, F.S.; granting review teams access to records at the request of the Department of Elderly Affairs; providing an effective date.

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

Section 1. Section 415.1103, Florida Statutes, is created to read:

415.1103 Elder Abuse Fatality Review Teams.—

(1) ESTABLISHMENT AND ORGANIZATION.—

(a) An elder abuse fatality review team may be established in each judicial circuit to review deaths of elderly persons alleged or found to have been caused by, or related to, abuse or neglect. The teams are housed, for administrative purposes only, in the Department of Elderly Affairs.

(b) A review team may include, but is not limited to, representatives from the following entities within the review team's judicial circuit:

1. Law enforcement agencies.
2. The state attorney.
3. The medical examiner.
4. A county court judge.
5. Adult protective services.
6. The Area Agency on Aging.
7. The State Long-Term Care Ombudsman Program.
8. The Agency for Health Care Administration.
9. The Office of the Attorney General.
10. The Office of the State Courts Administrator.
11. The clerk of the court.
12. A victim services program.
13. An elder law attorney.
14. Emergency services personnel.
15. A certified domestic violence center.

16. An advocacy organization for victims of sexual violence.

17. A funeral home director.

18. A forensic pathologist.

19. A geriatrician.

20. A geriatric nurse.

21. A geriatric psychiatrist or other individual licensed to offer behavioral health services.

22. A hospital discharge planner.

23. A public guardian.

24. Any other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence, including knowledge of research, policy, law, and other matters connected with such incidents or who are recommended for inclusion by the review team.

(c) Any person eligible to serve on a review team under paragraph (b) may initiate the establishment of a review team in his or her judicial circuit by requesting the Department of Elderly Affairs to call the first organizational meeting of the team. The Secretary of the Department of Elderly Affairs, or his or her designee, shall appoint the members of the review team in consultation with the entities under paragraph (b). At the initial meeting of a review team, members shall elect two members to serve as co-chairs.

(d) Participation in a review team is voluntary. Members

of the review teams shall serve without compensation and may not be reimbursed for per diem or travel expenses.

(e) Members of a review team shall serve for staggered terms of 2 years. The Secretary of Elderly Affairs may reappoint members for up to three consecutive terms. Co-chairs may be reelected by a majority of the review team for up to two consecutive terms.

(f) A review team shall determine the local operations of the team, including, but not limited to, the process for case selection, which shall be limited to closed cases in which an elderly person's death is alleged or found to have been caused by, or related to, abuse or neglect, and the meeting schedule, shall include at least one meeting in each fiscal year.

(g) Administrative costs of operating the review team shall be borne by the team members or entities whom they represent.

(2) DUTIES.—A review team shall:

(a) Review deaths of elderly persons in its judicial circuit found or alleged to have been caused by, or related to, abuse or neglect.

(b) Consider the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by systems and individuals related to the fatal incident.

(c) Identify gaps, deficiencies, or problems in the

delivery of services to elderly persons by public and private agencies which may be related to deaths reviewed by the review team.

(d) Whenever possible, develop a communitywide approach to address causes of and contributing factors to deaths reviewed by the review team.

(e) Develop practice standards and recommend changes in law, rules, and policies that support the care of elderly persons and prevent elder abuse deaths.

(3) RECORDS.—

(a) The Department of Elderly Affairs, on behalf of a review team, may request and shall be provided the following information or records pertaining to an elderly person whose death is being reviewed by a review team:

1. Information and records held by a criminal justice agency, as defined in s. 119.011, not including active criminal intelligence or investigative information, as defined in s. 119.011.

2. Information and records from Adult Protective Services pursuant to s. 415.107(3)(m).

3. An autopsy report from the medical examiner's office, not including materials protected under s. 406.135.

(b) Review team members may share with each other any relevant information that pertains to the review of the death of an elderly person.

(c) A team member may not contact, interview, or obtain information by request directly from a member of the deceased elderly person's family as part of the review, unless a team member is authorized to do so in the course of his or her employment duties. A member of the deceased elderly person's family may voluntarily provide records or information to a review team.

(4) ANNUAL REPORTS.—

(a) By September 1 of each year, each review team shall submit a report to the Department of Elderly Affairs, including, but not limited to:

1. Descriptive statistics regarding cases reviewed by the review team, including demographic information regarding victims and caregivers, and the causes and nature of elder deaths.

2. Current policies, procedures, rules, or statutes that the review team identified as contributing to the incidence of elder abuse and elder deaths, and recommendations for system improvement and needed resources, training, or information dissemination to address those identified issues.

3. Any other recommendations to prevent deaths from elder abuse based on an analysis of the data and information presented in the report.

4. Any steps taken by the review team and public and private agencies to implement necessary changes and improve the coordination of services and reviews.

(b) By November 1 of each year, the Department of Elderly Affairs shall prepare a summary report of the information required by paragraph (a), which shall be provided to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Department of Children and Families.

(5) Information and records acquired by a review team are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any state or local government department or agency if the information or records arose out of the matters that are the subject of review by a review team. However, information, documents, and records that are available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by a review team.

(6) A person who has attended a meeting of a review team or who has otherwise participated in the activities authorized by this section may not be permitted or required to testify in any civil, criminal, administrative, or disciplinary proceeding as to any records or information produced or presented to a review team during a meeting or other activity authorized by this section. However, this subsection does not prevent any person who testifies before the review team or who is a member of the review team from testifying as to matters otherwise within his or her knowledge.

(7) There is no monetary liability on the part of, and a cause of action for damages may not arise against, any member of a review team in the performance of his or her duties as a review team member, unless such member acted in bad faith, with wanton and willful disregard of human rights, safety, or property.

(8) Review teams and their members shall not disclose any information that is confidential pursuant to law.

Section 2. Paragraph (m) is added to subsection (3) of section 415.107, Florida Statutes, to read:

415.107 Confidentiality of reports and records.—

(3) Access to all records, excluding the name of the reporter which shall be released only as provided in subsection (6), shall be granted only to the following persons, officials, and agencies:

(m) The Department of Elderly Affairs on behalf of an elder abuse fatality review team established under s. 415.1103(1) that is reviewing the death of an elderly person.

Section 3. This act shall take effect July 1, 2018.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 679 Telepharmacy
SPONSOR(S): Health Quality Subcommittee; Ponder
TIED BILLS: **IDEN./SIM. BILLS:** SB 848

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

SUMMARY ANALYSIS

The Florida Pharmacy Act (Act) regulates the practice of pharmacy in Florida. The Board of Pharmacy (Board) adopts rules to implement the provisions of the Act and sets standards of practice within the state. Any person who operates a pharmacy in Florida must have a permit in one of the seven categories: community pharmacy, institutional pharmacy, nuclear pharmacy, special pharmacy, internet pharmacy, nonresident sterile compounding pharmacy, or special sterile compounding pharmacy. A pharmacist must be present and on duty for the prescription department of a pharmacy to be considered open; however the prescription department is not considered closed if the pharmacist briefly leaves to tend to personal needs or counsel patients.

Telepharmacy is generally defined as the provision of pharmaceutical care through the use of communication technologies. A pharmacist may provide such services as dispensing of medications, medication therapy management, clinical consultation, and patient counseling through telepharmacy. A number of states have adopted laws or regulations authorizing the use of telepharmacy to provide services to individuals who may have limited access to pharmaceutical care.

CS/HB 679 authorizes the Department of Health (DOH) to issue a permit for the operation of a remote dispensing site pharmacy. A remote dispensing site pharmacy is a location where medicinal drugs are dispensed by a registered pharmacy technician who is electronically supervised by an off-site prescription department manager. The bill requires that a registered pharmacy technician employed at a remote dispensing site pharmacy have at least 2,080 hours of experience.

In addition to meeting all the requirements in rule and statute for permitting pharmacies, a remote dispensing pharmacy must, among other things:

- Be jointly owned by a supervising pharmacy or operated under contract with a supervising pharmacy;
- Display a sign, visible by the public, which indicates that the facility is a remote dispensing site pharmacy and that it is under 24-hour video surveillance;
- Be located in a rural area and at least 10 miles from an existing community pharmacy; and
- Designate a licensed pharmacist or consultant pharmacist as the prescription department manager responsible for oversight of the facility.

DOH must perform an onsite inspection of the remote dispensing pharmacy prior to issuing a permit. A remote dispensing site pharmacy may not dispense or store Schedule II medicinal drugs, and the pharmacy technician may not perform sterile or nonsterile compounding of drugs.

The bill creates an exception to the requirement that a pharmacist be present and on duty for a prescription department of a pharmacy to be considered open. Under the bill, a prescription department may be considered open if an off-site prescription manager remotely supervises a pharmacy technician at a remote dispensing site pharmacy. A pharmacist may utilize telepharmacy to meet his or her obligation to be present and on duty and to supervise the pharmacy technician.

The prescription drug manager must visit the remote dispensing site pharmacy as required by the Board. A pharmacist may serve as a prescription department manager for one remote site dispensing pharmacy; however, a pharmacist may serve as a prescription department manager for up to two remote site dispensing pharmacies if they are under common control.

The bill will have an indeterminate, recurring negative fiscal impact and an insignificant, nonrecurring negative fiscal impact on DOH that can be absorbed with existing resources. The bill will have no fiscal impact on local governments.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Pharmacy Regulation

The Florida Pharmacy Act (act) regulates the practice of pharmacy in Florida and contains the minimum requirements for safe practice.[1] The Board of Pharmacy (Board) is tasked with adopting rules to implement the provisions of the act and setting standards of practice within the state.[2] Any person who operates a pharmacy in Florida must have a permit, and as of June 30, 2017, there were 9,835 permitted pharmacies in the state.[3] The following permits are issued by the Department of Health (DOH):

- Community pharmacy – A permit is required for each location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[4]
- Institutional pharmacy – A permit is required for every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medicinal drugs are compounded, dispensed, stored, or sold.[5]
- Nuclear pharmacy – A permit is required for every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. The term "nuclear pharmacy" does not include hospitals licensed under ch. 395, F.S., or the nuclear medicine facilities of such hospitals.[6]
- Special pharmacy – A permit is required for every location where medicinal drugs are compounded, dispensed, stored, or sold if the location does not otherwise meet an applicable pharmacy definition in s. 465.003, F.S.[7]
- Internet pharmacy – A permit is required for a location not otherwise licensed or issued a permit under this chapter, within or outside this state, which uses the Internet to communicate with or obtain information from consumers in this state to fill or refill prescriptions or to dispense, distribute, or otherwise practice pharmacy in this state.[8]
- Nonresident sterile compounding pharmacy – A permit is required for a registered nonresident pharmacy or an outsourcing facility to ship, mail, deliver, or dispense, in any manner, a compounded sterile product into this state.[9]
- Special sterile compounding – A separate permit is required for a pharmacy holding an active pharmacy permit that engages in sterile compounding.[10]

A pharmacy must pass an on-site inspection for a permit to be issued,[11] and the permit is valid only for the name and address to which it is issued.[12]

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[1] Chapter 465, F.S.
[2] Sections 465.005, 465.0155, and 465.022, F.S.
[3] Department of Health, *2018 Agency Legislative Bill Analysis for House Bill 679*, (Nov. 15, 2018), on file with the Health Quality Subcommittee.
[4] Sections 465.003(11)(a)1. and 465.018, F.S.
[5] Sections 465.003(11)(a)2. and 465.019, F.S.
[6] Sections 465.003(11)(a)3. and 465.0193, F.S.
[7] Sections 465.003(11)(a)4. and 465.0196, F.S.
[8] Sections 465.003(11)(a)5. and 465.0197, F.S.
[9] Section 465.0158, F.S.
[10] Rules 64B16-2.100 and 64B16-28.802, F.A.C. An outsourcing facility is considered a pharmacy and need to hold a special sterile compounding permit if it engages in sterile compounding.
[11] Id.
[12] Rule 64B16-28.100, F.A.C.

Regulation of Pharmacists and Pharmacy Technicians

Pharmacists

Licensure Requirements

A pharmacist is a person who is licensed under the act to practice the profession of pharmacy.[13] To be licensed as a pharmacist in Florida, a person must:[14]

- Be at least 18 years of age;
- Complete an application and remit an examination fee;
- Hold a degree from an accredited and approved school or college of pharmacy;[15]
- Have completed a Board-approved internship; and
- Successfully complete the Board-approved examination.

During each biennial licensure renewal cycle, a pharmacist must complete at least 30 hours of Board-approved continuing education.[16] If a pharmacist is certified to administer vaccines or epinephrine, the pharmacist must complete a 3-hour continuing education course on the safe and effective administration of vaccines and epinephrine autoinjections as a part of the biennial licensure renewal.[17]

Scope of Practice

The practice of the profession of pharmacy includes:[18]

- Compounding,[19] 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;[20]
- Administering epinephrine injections;[21] and
- Administering antipsychotic medications by injection.[22]

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[13] Section 465.003(10), F.S.
[14] Section 465.007, F.S. DOH may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[15] 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.
[16] Section 465.009, F.S.
[17] Section 465.009(6), F.S.
[18] Section 465.003(13), F.S.
[19] Rule 64B16-27.700, F.A.C., defines compounding a professional act by a pharmacist incorporating ingredients to create a finished product for dispensing to a patient or to a practitioner for administration to a patient. The American Pharmacists Association, citing the U.S. Pharmacopeia Convention (USP) defines compounding as "the preparation, mixing, assembling, altering, packaging, and labeling of a drug, drug-delivery device, or device in accordance with a licensed practitioner's prescription, medication order, or initiative based on the practitioner/patient/ pharmacist/compounder relationship in the course of professional practice." *See* http://www.pharmacist.com/frequently-asked-questions-about-pharmaceutical-compounding (last visited January 9, 2018).
[20] *See* s. 465.189, F.S.
[21] Id.
[22] Section 465.1893, F.S.

Pharmacists are specifically prohibited from altering a prescriber's directions, diagnosing or treating any disease, initiating any drug therapy, and practicing medicine or osteopathic medicine, unless permitted by law.[23]

Only a pharmacist or registered intern may:[24]

- Supervise or be responsible for the controlled substance inventory;
- Receive verbal prescriptions from a prescriber;
- Interpret and identify prescription contents;
- Engage in consultation with a health care practitioner regarding the interpretation of a prescription and date in a patient's profile record;
- Engage in professional communication with health care practitioners;
- Advise or consult with a patient, both as to the prescription and the patient profile record; and
- Perform certain duties related to the preparation of parenteral and bulk solutions.

Pharmacists must perform the final check of a completed prescription, thereby assuming complete responsibility for its preparation and accuracy.[25] A pharmacist must be personally available at the time of dispensing.[26] A prescription department is considered closed if a Florida-licensed pharmacist is not present and on duty unless the pharmacist leaves the prescription department to:[27]

- Consult, respond to inquiries, or provide assistance to customers or patients;
- Attend to personal hygiene needs; or
- Perform functions for which the pharmacist is responsible provided that such activities are performed in a manner that is consistent with the pharmacist's responsibility to provide pharmacy services.

Prescription Department Managers

Each community pharmacy must have designate a licensed pharmacist as a prescription department manager.[28] The prescription drug manager is responsible for maintaining all drug records, providing for the security of the prescription department, and ensuring that the all regulations of the practice of the profession of pharmacy are followed.[29] A pharmacist may only serve as the prescription department manager of one pharmacy.[30] However, the Board may grant an exception based on circumstances, such as the proximity of the pharmacies and the workload of the pharmacist.

Pharmacy Technicians

Registration Requirements

Pharmacy technicians assist pharmacists in dispensing medications and are accountable to a supervising pharmacist who is legally responsible for the care and safety of the patients served.[31] A person must register with DOH to practice as a pharmacy technician. To register, an individual must:[32]

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[23] *Supra* note 18.
[24] Rule 64B16-27.1001(1)-(2), F.A.C. Section 465.003(12), F.S., defines a pharmacy intern as a person who is currently registered in, and attending, or is a graduate of a duly accredited college or school of pharmacy and is properly registered with DOH. The American Pharmacist Association, citing the U.S.
[25] Rule 64B16-27.1001(3), F.A.C.
[26] Rule 64B16-27.1001(4), F.A.C.
[27] Section 465.003(11)(b), F.S.
[28] Rules 64B16-27.104 and 64B16-27.450, F.A.C.
[29] Id.
[30] Id.
[31] Pharmacy Technician Certification Board, *Pharmacy Technicians*, available at https://www.ptcb.org/who-we-serve/pharmacy-technicians#.Wj1PsGyouUk (last visited on December 22, 2017).
[32] Section 465.014(2), F.S.

- Be at least 17 years of age;
- Submit an application and remit an application fee; and
- Complete a Board-approved pharmacy technician training program.[33]

The pharmacy technician must renew the registration biennially. For each renewal cycle, a pharmacy technician must complete 20 continuing education hours, 4 of which must be live.[34]

Pharmacy Technician Training Programs

A pharmacy technician may only be registered with DOH if it completes a Board-approved training program. These include pre-approved training programs that were accredited on or before April 1, 2017, by certain accreditation entities, such as the Accreditation Council on Pharmacy Education, as well as pharmacy technician training programs provided by a branch of the United States Armed Forces whose curriculum was developed on or before April 1, 2017.[35]

The Board may review and approve other training programs that do not meet the criteria for pre-approval. Such programs must be licensed by the Commission for Independent Education or equivalent licensing authority or be within the public school system of this state, and offer a course of study that includes:[36]

- Introduction to pharmacy and health care systems;
- Confidentiality;
- Patient rights and the Health Insurance Portability and Accountability Act (HIPAA);
- Relevant federal and state law;
- Pharmaceutical topics, including medical terminology, abbreviations, and symbols; medication safety and error prevention; and prescriptions and medication orders;
- Records management and inventory control, including pharmaceutical supplies, medication labeling, medication packaging and storage, controlled substances, and adjudication and billing;
- Interpersonal relations and ethics, including diversity of communications, empathetic communications, ethics governing pharmacy practice, patient and caregiver communications; and
- Pharmaceutical calculations.

The training program must provide the Board with educational and professional background of its faculty.[37] A licensed pharmacist or registered pharmacy technician with appropriate expertise must be involved with planning and instruction and must supervise learning experiences.[38]

The Board may also review and approve employer-based pharmacy technician training programs. An employer-based program must be offered by a Florida-permitted pharmacy, or affiliated group of pharmacies under common ownership.[39] The program must consist of 160 hours of training over a period of no more than 6 months and may only be provided to the employees of that pharmacy.[40] The employer-based training program must:[41]

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[33] An individual is exempt from the training program if he or she was registered as a pharmacy technician before January 1, 2011, and either worked as a pharmacy technician at least 1,500 hours under a licensed pharmacists or received certification from an accredited pharmacy technician program.
[34] Section 465.014(6), F.S.
[35] Rule 64B16-26.351(1)-(2), F.A.C.
[36] Rule 64B16-26.351(3)(b), F.A.C.
[37] Rule 64B16-26.351(3)(e), F.A.C.
[38] Id.
[39] Rule 64B16-26.351(4), F.A.C.
[40] Id.
[41] Id.

- Meet the same qualifications as required for non-employment based pharmacy technician training programs as indicated above;
- Provide an opportunity for students to evaluate learning experiences, instructional methods, facilitates, and resources;
- Ensure that self-directed learning experience, such as home study or web-based courses, evaluate the participant's knowledge at the completion of the learning experience; and
- Designate a person to assume responsibility for the registered pharmacy technician training program.

Scope of Practice

A registered pharmacy technician may not engage in the practice of the profession of pharmacy; however, a licensed pharmacist may delegate those duties, tasks, and functions that do not fall within the definition of the practice of professional pharmacy.[42] Registered pharmacy technicians' responsibilities include: [43]

- Retrieval of prescription files;
- Data entry;
- Label preparation;
- Counting, weighing, measuring, and pouring of prescription medication;
- Initiation of communication with a prescribing practitioner regarding requests for prescription refill authorization, obtaining clarification on missing or illegible information on prescriptions, and confirmation of information such as names, medication, strength, directions, and refills;
- Acceptance of authorization for prescription renewals; and
- Any other mechanical, technical, or administrative tasks which do not themselves constitute the practice of the profession of pharmacy.

A licensed pharmacist must directly supervise the performance of a registered pharmacy technician,[44] and is responsible for acts performed by persons under his or her supervision.[45] A pharmacist may use technological means to communicate with or observe a registered pharmacy technician who is performing delegated tasks.[46]

The Board specifies, by rule, certain acts that registered pharmacy technicians are prohibited from:[47]

- Receiving new verbal prescriptions or any change in the medication, strength, or directions of an existing prescription;
- Interpreting a prescription or medication order for therapeutic acceptability and appropriateness;
- Conducting a final verification of dosage and directions;
- Engaging in prospective drug review;
- Monitoring prescription drug usage;
- Transferring a prescription;
- Overriding clinical alerts without first notifying the pharmacist;
- Preparing a copy of a prescription or reading a prescription to any person for the purpose of providing reference concerning treatment of the patient for whom the prescription was written;
- Engaging in patient counseling; or

[42] Section 465.014(1), F.S.
[43] Rule 64B16-27.420(1), F.A.C.
[44] Direct supervision means supervision by a pharmacist who is on the premises at all times the delegated tasks are being performed; who is aware of delegated tasks being performed; and who is readily available to provide personal assistance, direction, and approval throughout the time the delegated tasks are being performed (r. 64B16-27.4001(2)(a), F.A.C.)
[45] Rule 64B16-27.1001(7), F.A.C.
[46] Rule 64B16-27.4001(2)(b), F.A.C.
[47] Rule 64B16-27.420(2), F.A.C.

- Engaging in any other act that requires the exercise of a pharmacist's professional judgment.

A registered pharmacy technicians must wear an identification badge with a designation as a "registered pharmacy technician" and identify herself or himself as a registered pharmacy technician in telephone or other forms of communication.[48]

Pharmacist-to-Technician Ratios

Florida law prohibits a pharmacist from supervising more than one registered pharmacy technician, unless otherwise permitted by guidelines adopted by the Board.[49] The guidelines include the following restrictions:[50]

- A pharmacist engaging in sterile compounding may supervise up to 3 registered pharmacy technicians.
- A pharmacist who is not engaged in sterile compounding may supervise up to 4 registered pharmacy technicians.
- In a pharmacy that does not dispense medicinal drugs, a pharmacist may supervise up to 6 registered pharmacy technicians, as long as the pharmacist or pharmacy is not involved in sterile compounding.
- In a pharmacy that dispenses medicinal drugs in a physically separate area[51] of the pharmacy from which medicinal drugs are not dispensed, a pharmacist may supervise up to 6 registered pharmacy technicians.

Telehealth

There is no universally accepted definition of telehealth. In broad terms, telehealth is:

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment[52] and prevention of disease and injuries[53], research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.[54]

More specific definitions vary by state and occasionally by profession.[55] There are, however, common elements among the varied definitions of telehealth.

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[48] Rule 64B16-27.100(2), F.A.C.
[49] Section 465.014(1), F.S.
[50] Rule 64B16-27.410, F.A.C.
[51] A "physically separate area" is a part of the pharmacy which is separated by a permanent wall or other barrier which restricts access between the two areas.
[52] The University of Florida's Diabetes Institute utilizes telehealth to deliver treatment to children with diabetes and other endocrine problems who live in Volusia County. This allows the children to receive specialized treatment without the necessity of traveling from Volusia County to Gainesville. The Florida Department of Health's Children's Medical Services underwrites the program. *See* https://ufhealth.org/diabetes-center-excellence/telemedicine (last visited on January 2, 2018).
[53] The University of South Florida has partnered with American Well to provide health care services to the residents of the Villages via telehealth. The goal is to reduce hospital admissions, readmission rates, and pharmacy costs, while maintaining Medicare beneficiaries in their homes rather than long-term care settings. *See* http://hscweb3.hsc.usf.edu/blog/2012/06/22/usf-health-and-american-well-to-bring-telehealth-to-seniors-living-at-the-villages/ (last visited on January 2, 2018).
[54] World Health Organization, *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2*, Section 1.2, page 9 (2010), available at http://apps.who.int/iris/bitstream/10665/44497/1/9789241564144_eng.pdf (last visited on January 2, 2018).
[55] Center for Connected Health Policy, The National Telehealth Policy Resource Center, *State Telehealth Laws and Medicaid Program Policies*, (August 2016), *available at* http://www.cchpca.org/sites/default/files/resources/50%20STATE%20COMPLETE%20REPORT%20PASSWORD%20AUG%202016_1.pdf (last visited on January 2, 2018)

Telehealth generally consists of synchronous and/or asynchronous transmittal of information.[56] Synchronous refers to the live[57] transmission of information between patient and provider during the same time period.[58] Asynchronous telehealth is the transfer of data over a period of time, and typically in separate time frames.[59] This is commonly referred to as "store and forward." Definitions of telehealth also commonly contain restrictions related to the location where telehealth may be used. For example, the use of the "hub and spoke" model is a common location restriction. A hub site is the location from which specialty or consultative services originate, i.e., the provider.[60] A spoke site is a remote site where the patient is presented during the telehealth encounter.[61] Under this model, health services may be provided through telehealth only if the patient is located at a designated spoke site and the provider is located at a designated hub site.

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.[62]

Telepharmacy

Telepharmacy is the provision of pharmaceutical care by pharmacies and pharmacists through the use of telepharmacy technologies to patients or their agents at a distance.[63] Telepharmacy operations include, but are not limited to, drug review and monitoring, dispensing of medications, medication therapy management, clinical consultation, and patient counseling.[64]

In 2001, North Dakota became the first state to regulate telepharmacy.[65] North Dakota created a pilot project using telepharmacy to save rural pharmacies from closing and to provide telepharmacy services to underserved rural communities in that state.[66] The pilot project authorized community pharmacies to open and operate telepharmacy sites in rural communities without a pharmacist being physically present to supervise a registered pharmacy technician working at the remote site.[67] A pharmacist supervises the pharmacy technician and speaks with patients using real-time communications

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[56] The majority of telehealth definitions allow for both synchronous and asynchronous transmittal of information. Some definitions however omit asynchronous from the definition of telehealth.
[57] This is also referred to as "real time" or "interactive" telehealth.
[58] American Telemedicine Association, *Telemedicine Glossary*, available at http://thesource.americantelemed.org/resources/telemedicine-glossary (last visited on January 2, 2018). The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.
[59] Id. A common example of synchronous telehealth is the transfer of x-rays or MRI images from one health care provider to another health care provider for review in the future.
[60] Id.
[61] Id.
[62] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine*, (August 2016), available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited January 2, 2018).
[63] National Association of Boards of Pharmacy, "Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy," (Aug. 2017), available at https://nabp.pharmacy/publications-reports/resource-documents/model-pharmacy-act-rules/ (last visited January 2, 2018). Telepharmacy technologies means secure electronic communications, information exchange, or other methods that meet state and federal requirements.
[64] E. Alexander et al, *ASHP Statement on Telepharmacy*, 74 AM J HEALTH-SYSTEM PHARM., e236 (May 2017), available at http://www.ajhp.org/content/74/9/e236?sso-checked=true (last visited January 2, 2018).
[65] George Tzanetakos et al, RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, *Rural Policy Brief: Telepharmacy Rules and Statutes: 50-State Survey*, Brief No. 2017-4, (April 2017), available at https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2017/Telepharmacy%20Rules%20and%20Statutes.pdf (last visited January 2, 2018).
[66] Daniel L. Friesner et al, *Do Remote Community Telepharmacies Have Higher Medication Error Rates than Traditional Community Pharmacies? Evidence from the North Dakota Telepharmacy Project*, 51 J AM PHARM ASSOC., 580 (Sept./Oct. 2011), available at https://www.ndsu.edu/fileadmin/telepharmacy/APhA_article_2011_-_Copy.pdf last visited January 5, 2018).
[67] Id at 582.

technology.[68] Almost 80,000 rural citizens had pharmacy services established, restored, or retained under the pilot project.[69]

At least 23 states have enacted laws or regulations that allow for the use of telepharmacy and/or remote dispensing since 2001.[70] The regulation of telepharmacy and remote dispensing varies by state. Some states geographically limit the provision of telepharmacy services to ensure that remote dispensing sites are only established in rural areas or medically underserved areas[71] while others restrict it by facility type such as rural health centers.[72] Many states have included minimum staffing and education requirements, such as requiring a minimum level of experience for the pharmacy technicians or limiting the number of pharmacy technicians that a pharmacist may supervise.[73]

Rural Areas

There are a number of rural areas in Florida in which access to health care may be limited. Both the state and federal government have advanced policy and programs to ensure that individuals residing in rural communities have access to quality health care. The Office of Rural Health, within DOH, is tasked with actively fostering the provision of health care services in rural areas and serving as a catalyst for improved health services to residents in these areas.[74] A rural area is an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States census as rural.[75] DOH has designated the following counties as rural areas:[76]

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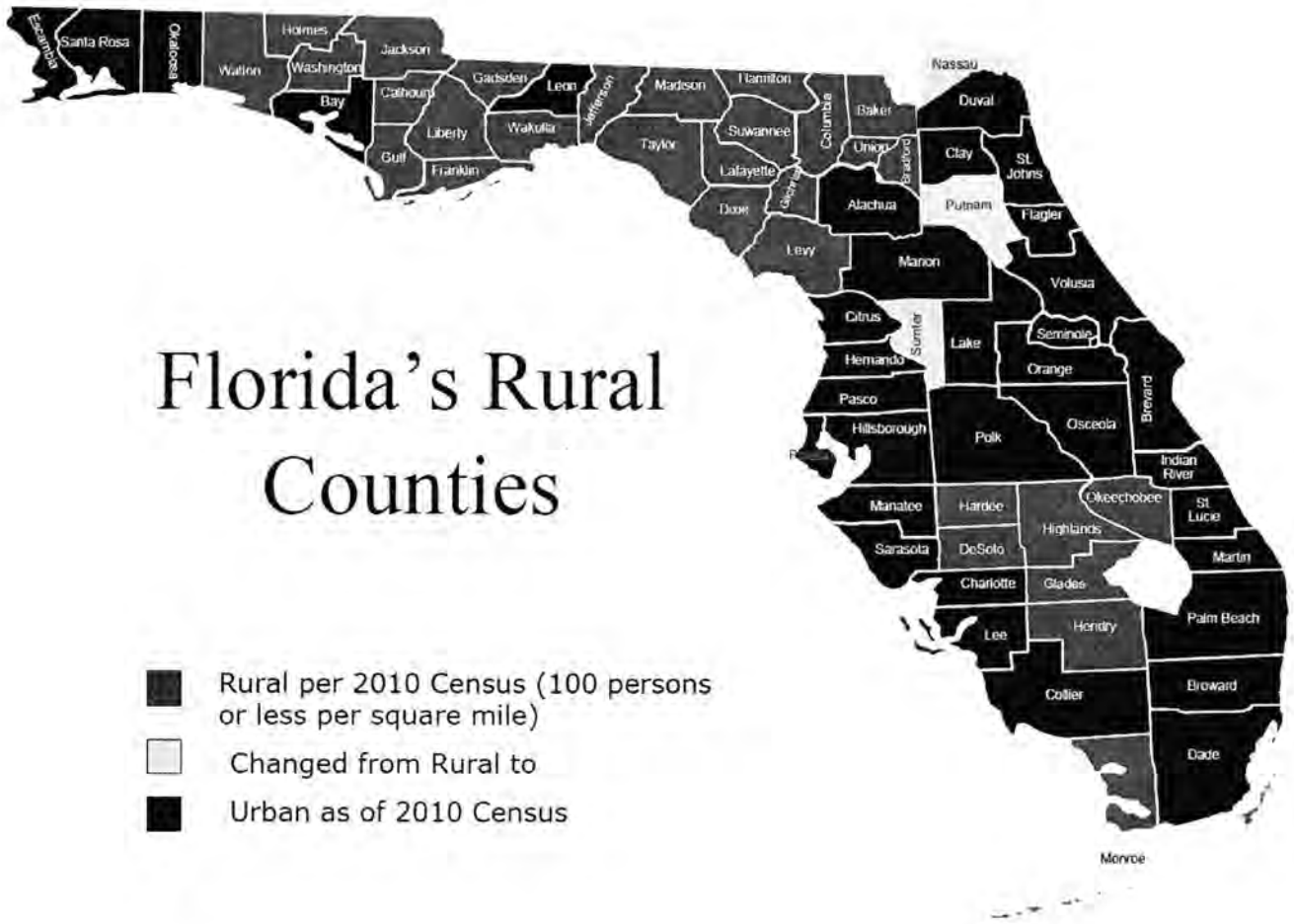
[68] Id.
[69] National Association of Boards of Pharmacy, *Telepharmacy: The New Frontier of Patient Care and Professional Practice*, 46 INNOVATIONS 46 (June/July 2017), available at https://nabp.pharmacy/wp-content/uploads/2016/07/Innovations_June_July_Final.pdf (last visited January 5, 2018).
[70] *Supra* note 65. These states include Alaska, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, and Wyoming.
[71] Id. For example, Colorado requires that a telepharmacy outlet be more than twenty miles from the nearest prescription drug outlet or another telepharmacy outlet. (COLO. REV. STAT. s. 12-12.5-102 (2017)).
[72] Id. For example, Wisconsin limits the operation of a remote dispensing site to a health care facility, office or clinic of a practitioner, county jail, rehabilitation facility, state prison, county house of correction, juvenile correctional facility, juvenile detention center, or residential care center for children and youth. (Wis. Admin. Code s. Phar. 7.095(3)).
[73] Id. For example, Illinois requires a pharmacy technician to have at least one year of experience and prohibits a pharmacist from supervising more than three sites that are simultaneously open. (Ill. Admin. Code tit. 68, s. 1330.510).
[74] Section 381.0405.
[75] Section 381.0406(2)(a), F.S.
[76] Department of Health, *Florida's Rural Counties*, available at http://www.floridahealth.gov/programs-and-services/community-health/rural-health/_documents/ruralcountiespdf.12.pdf (last visited January 18, 2018). For a list of counties, *see* http://www.floridahealth.gov/programs-and-services/community-health/rural-health/_documents/rual-counties-2000-2010.pdf (last visited January 18, 2018).



Effect of Proposed Changes

CS/HB 679 creates a remote dispensing site pharmacy permit. A remote dispensing site pharmacy is a location where medicinal drugs are dispensed by a registered pharmacy technician who is electronically supervised by an off-site prescription department manager.

Remote Dispensing Site Pharmacy

The bill requires a DOH-issued permit to operate a remote dispensing site pharmacy. A remote dispensing site pharmacy must:

- Be jointly owned by a supervising pharmacy or operated under contract with a supervising pharmacy;[77]
- Display a sign, visible by the public, which indicates that the facility is a remote dispensing site pharmacy and that it is under 24-hour video surveillance;
- Retain video surveillance recordings for at least 45 days;
- Be located in a rural area, which is defined as a having a population density of less than 100 people per square mile or designated as rural by the most recent United States census;[78]
- Be located at least 10 miles from an existing community pharmacy;

[77] The bill defines a supervising pharmacy as a Florida-licensed pharmacy that employs a Florida-licensed pharmacist who remotely supervises a registered pharmacy technician at a remote dispensing site pharmacy.
[78] Section 381.0406, F.S.

- Designate a licensed pharmacist or consultant pharmacist as the prescription department manager responsible for oversight of the facility; and
- Pass an onsite inspection by DOH.

DOH must issue a permit if the Board certifies that an application for a permit complies with the laws and rules governing pharmacies. A remote dispensing site pharmacy will not lose its permit if a community pharmacy subsequently opens within 10 miles of its location. For purposes of network access in managed care, a remote dispensing site pharmacy is not considered a pharmacy.

Operation of a Remote Dispensing Site Pharmacy

The bill authorizes a remote dispensing site pharmacy to store, hold, and dispense all medicinal drugs; however, it may not store, hold, or dispense Schedule II controlled substances.[79] It may not perform centralized prescription filling, which is the filing of a prescription by one pharmacy upon the request of another pharmacy.[80]

The bill creates an exception to the requirement that a pharmacist be present and on duty for a prescription department of a pharmacy to be considered open. Under the bill, a prescription department may be considered open if an off-site prescription manager remotely supervises a pharmacy technician at a remote dispensing site pharmacy. A pharmacist may utilize telepharmacy to meet his or her obligation to be present and on duty and to supervise the pharmacy technician.

A remote dispensing site pharmacy must maintain a policy and procedures manual that addresses:

- How the pharmacy will comply with federal and state laws, rules, and regulations;
- The procedure for supervising the remote dispensing site pharmacy and counseling its patients;
- The procedure for reviewing the prescription drug inventory and drug records;
- The policy and procedure for providing appropriate security to protect the confidentiality and integrity of patient information;
- A written plan for recovery from an event that interrupts or prevents the pharmacist from supervising the remote dispensing site pharmacy's operation;
- The procedure by with the supervising pharmacist consults the state prescription drug management program before authorizing the dispensing of any controlled substance and reports the dispensing of a controlled substance;[81] and
- The duties, tasks, and functions that a registered pharmacy technician is authorized to perform.

The prescription drug manager must visit the remote dispensing site pharmacy, pursuant to a schedule established by the Board, to inspect the pharmacy, address personnel matters, and provide clinical services to patients. A pharmacist may serve as a prescription department manager for one remote site dispensing pharmacy; except that a pharmacist may serve as a pharmacy department manager for up to two remote site dispensing pharmacies if they are under common control.

Pharmacy Technicians

The bill authorizes a registered pharmacy technician working in a remote site dispensing pharmacy under the electronic supervision of a pharmacist to compound and dispense medicinal drugs. A registered pharmacy technician employed by a remote dispensing site pharmacy must have completed

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[79] Section 893.03(2), F.S., defines a Schedule II drug as a substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment, and the abuse of the substance may lead to severe psychological or physical dependence.

[80] Section 465.003(16), F.S. It also includes the performance of other pharmacy duties by one pharmacy on behalf of another pharmacy, such as drug utilization review, claims adjudication, and obtaining refill authorizations.

[81] Pursuant to s. 893.055, F.S., each time a controlled substance is dispensed, the dispenser must submit certain information to the state's prescription drug management program by the close of the next business day.

at least 2,080 hours of pharmacy experience prior to commencing employment. The bill prohibits a registered pharmacy technician from performing sterile or nonsterile compounding.

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Amends s. 465.003, F.S., relating to definitions.
Section 2: Amends s. 465.014, F.S., relating to pharmacy technician.
Section 3: Amends s. 465.015, F.S., relating to violations and penalties.
Section 4: Creates s. 465.0198, F.S., relating to remote dispensing site pharmacy permits.
Section 5: Amends s. 465.022, F.S., relating to pharmacies; general requirements; fees.
Section 6: Amends s. 465.0265, F.S., relating to centralized prescription filing.
Section 7: Provides an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Pursuant to 465.022(14), the Board is authorized to set an initial permit fee of no more than $250 and a biennial renewal fee of no more than $250. It is unknown how many permittees there may be.

2. Expenditures:

   The bill will have an indeterminate, negative fiscal impact on DOH due to a recurring increase in costs and workload associated with issuing the remote dispensing site pharmacy permits and regulating permittees.[82] It is estimated the fees collected will offset the permit and regulation costs.

   DOH will also incur an insignificant, nonrecurring negative fiscal impact associated with the development of an application form and updates to the Licensing and Enforcement Information Database System, which current resources can absorb.[83]

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

[82] Florida Department of Health, *2018 Agency Legislative Bill Analysis for Senate Bill 848*, (Nov. 13, 2017), on file with the Health Quality Subcommittee. SB 848 is substantively similar to HB 679.
[83] Id.

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:

Section 465.005, F.S., grants the Board of Pharmacy broad rulemaking authority to implement the provisions of ch. 465, F.S. Therefore, no additional rulemaking authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 16, 2018, the Health Quality Subcommittee adopted a strike-all amendment that did the following:

- Required a remote dispensing site pharmacy to pass an onsite inspection to qualify for a permit;
- Required that a remote dispensing site pharmacy be located in an area defined as rural under s. 381.0406, F.S., (less than 100 people per square mile or designated as rural by the most recent U.S. census);
- Removed exceptions that would have allowed a remote dispensing site pharmacy to be located within 10 miles of an existing community pharmacy;
- Prohibited a remote dispensing site pharmacy from storing or dispensing Schedule II drugs;
- Required the policies and procedures manual of a remote dispensing site pharmacy to contain procedures to comply with the requirements of the prescription drug monitoring program;
- Established a minimum experience requirement for a pharmacy technician employed at a remote dispensing site pharmacy of at least 2,080 hours of experience within the 2 years immediately preceding employment; and
- Prohibited a pharmacy technician working at a remote dispensing site pharmacy from performing sterile and nonsterile compounding.

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

A bill to be entitled

An act relating to telepharmacy; amending s. 465.003, F.S.; revising and providing definitions; amending s. 465.014, F.S.; authorizing a registered pharmacy technician to dispense medicinal drugs under certain conditions; amending s. 465.015, F.S.; conforming provisions to changes made by the act; creating s. 465.0198, F.S.; providing permit requirements for remote dispensing site pharmacies; providing requirements and prohibitions for a remote dispensing site pharmacy; requiring the prescription department manager to visit the remote dispensing site pharmacy; providing an experience requirement for a registered pharmacy technician working at a remote site pharmacy; prohibiting a registered pharmacy technician from performing sterile or nonsterile compounding; providing construction; amending s. 465.022, F.S.; authorizing a Florida licensed pharmacist to serve as the prescription drug manager at more than one remote dispensing site pharmacy under certain conditions; amending s. 465.0265, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsection (11) of section 465.003, Florida Statutes, is amended to read:

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

(11)(a) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, ~~and~~ an Internet pharmacy, and a remote dispensing site pharmacy.

1. The term "community pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.

2. The term "institutional pharmacy" includes every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility, hereinafter referred to as "health care institutions," where medicinal drugs are compounded, dispensed, stored, or sold.

3. The term "nuclear pharmacy" includes every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. The term "nuclear pharmacy" does not include hospitals licensed under chapter 395 or the nuclear medicine facilities of such hospitals.

4. The term "special pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold if such locations are not otherwise defined in this subsection.

5. The term "Internet pharmacy" includes locations not otherwise licensed or issued a permit under this chapter, within or outside this state, which use the Internet to communicate with or obtain information from consumers in this state and use such communication or information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state. Any act described in this definition constitutes the practice of pharmacy as defined in subsection (13).

6. The term "remote dispensing site pharmacy" includes every location where medicinal drugs are dispensed by a registered pharmacy technician who is electronically supervised by an off-site prescription department manager.

(b) The pharmacy department of any permittee shall be considered closed whenever a Florida licensed pharmacist is not present and on duty. The term "not present and on duty" shall not be construed to prevent:

1. A pharmacist from exiting the prescription department for the purposes of consulting or responding to inquiries or providing assistance to patients or customers;~~,~~

2. A pharmacist attending to personal hygiene needs;~~, or~~

3. A pharmacist performing any other function for which the pharmacist is responsible, provided that such activities are conducted in a manner consistent with the pharmacist's responsibility to provide pharmacy services; or

4. An off-site pharmacist from remotely supervising a registered pharmacy technician at a remote dispensing site pharmacy.

Section 2. Subsection (1) of section 465.014, Florida Statutes, is amended to read:

465.014 Pharmacy technician.—

(1) A person other than a licensed pharmacist or pharmacy intern may not engage in the practice of the profession of pharmacy, except that a licensed pharmacist may delegate to pharmacy technicians who are registered pursuant to this section those duties, tasks, and functions that do not fall within the purview of s. 465.003(13). However, a registered pharmacy technician may dispense medicinal drugs when operating under the electronic supervision of an off-site Florida licensed pharmacist pursuant to s. 465.0198. All such delegated acts must be performed under the direct supervision of a licensed pharmacist who is responsible for all such acts performed by persons under his or her supervision. A registered pharmacy technician, under the supervision of a pharmacist, may initiate or receive communications with a practitioner or his or her agent, on behalf of a patient, regarding refill authorization requests. A licensed pharmacist may not supervise more than one registered pharmacy technician unless otherwise permitted by the guidelines adopted by the board. The board shall establish guidelines to be followed by licensees or permittees in

determining the circumstances under which a licensed pharmacist may supervise more than one pharmacy technician.

Section 3. Subsections (1) and (2) of section 465.015, Florida Statutes, are amended to read:

465.015 Violations and penalties.—

(1) It is unlawful for any person to own, operate, maintain, open, establish, conduct, or have charge of, either alone or with another person or persons, a pharmacy:

(a) Which is not registered under the provisions of this chapter.

(b) In which a person not licensed as a pharmacist in this state or not registered as an intern in this state or in which an intern who is not acting under the direct and immediate personal supervision of a licensed pharmacist fills, compounds, or dispenses any prescription or dispenses medicinal drugs. This paragraph does not apply to any person who owns, operates, maintains, opens, establishes, conducts, or has charge of a remote dispensing site pharmacy pursuant to s. 465.0198.

(2) It is unlawful for any person:

(a) To make a false or fraudulent statement, either for herself or himself or for another person, in any application, affidavit, or statement presented to the board or in any proceeding before the board.

(b) To fill, compound, or dispense prescriptions or to dispense medicinal drugs if such person does not hold an active

license as a pharmacist in this state, is not registered as an intern in this state, or is an intern not acting under the direct and immediate personal supervision of a licensed pharmacist. This paragraph does not apply to a registered pharmacy technician dispensing medicinal drugs pursuant to s. 465.0198.

(c) To sell or dispense drugs as defined in s. 465.003(8) without first being furnished with a prescription.

(d) To sell samples or complimentary packages of drug products.

Section 4. Section 465.0198, Florida Statutes, is created to read:

465.0198 Remote dispensing site pharmacy permits.—

(1) Any person desiring a permit to operate a remote dispensing site pharmacy shall apply to the department for a remote dispensing site pharmacy permit. If the board certifies that the application complies with the laws and rules of the board governing the practice of the profession of pharmacy, the department shall issue the permit. A permit may not be issued unless a licensed pharmacist or consultant pharmacist is designated as the prescription department manager responsible for the oversight of the remote dispensing site pharmacy. The permittee must notify the department within 10 days after any change of the prescription department manager.

(2) As a prerequisite to issuance of an initial permit or

a permit for a change of location, the remote site pharmacy must pass an onsite inspection. The department must make the inspection within 90 days before issuance of the permit.

(3) The remote dispensing site pharmacy must:

(a) Be jointly owned by a supervising pharmacy or operated under a contract with a supervising pharmacy. For purposes of this subsection, "supervising pharmacy" means a licensed pharmacy in this state that employs a Florida licensed pharmacist who remotely supervises a registered pharmacy technician at a remote dispensing site pharmacy.

(b) Display a sign visible to the public indicating that the location is a remote dispensing site pharmacy and that the facility is under 24-hour video surveillance. The remote dispensing site pharmacy must retain the video surveillance recordings for at least 45 days.

(c) Be located in an area defined as rural pursuant to s. 381.0406.

(d) Be at least 10 miles from an existing community pharmacy.

(4) A remote dispensing site pharmacy may not lose its permit based on the subsequent opening of a community pharmacy within 10 miles of the remote dispensing site pharmacy.

(5) A remote dispensing site pharmacy is not considered a pharmacy location for purposes of network access in managed care programs.

(6) A remote dispensing site pharmacy may store, hold, and dispense all medicinal drugs including those listed in s. 893.03(3)-(5). A remote dispensing pharmacy may not store, hold, or dispense controlled substances listed in s. 893.03(2).

(7) A remote dispensing site pharmacy may not perform centralized prescription filling, as defined in s. 465.003(16).

(8) A remote dispensing site pharmacy must maintain a policy and procedures manual, which shall be made available to the board or its agent upon request. The policy and procedures manual shall include:

(a) A description of how the pharmacy will comply with federal and state laws, rules, and regulations.

(b) The procedure for supervising the remote dispensing site pharmacy and counseling its patients prior to the dispensing of any medicinal drug pursuant to this section.

(c) The procedure for reviewing the prescription drug inventory and drug records maintained by the remote dispensing site pharmacy.

(d) The policy and procedure for providing appropriate security to protect the confidentiality and integrity of patient information.

(e) The written plan for recovery from an event that interrupts or prevents the pharmacist from supervising the remote dispensing site pharmacy's operation.

(f) The procedure by which a supervising pharmacist

consults the state prescription drug monitoring program before authorizing any controlled substance for dispensing and submits the dispensing of a controlled substance as required under s. 893.055.

(g) The specific duties, tasks, and functions that a registered pharmacy technician is authorized to perform at the remote dispensing site pharmacy.

(9) The prescription department manager must visit the remote dispensing site pharmacy, based on a schedule designated by the board, to inspect the pharmacy, address personnel matters, and provide clinical services for patients.

(10) A registered pharmacy technician must have completed at least 2,080 hours of experience at a pharmacy within the 2 years immediately preceding the date on which the registered pharmacy technician begins employment at the remote dispensing site pharmacy.

(11) A registered pharmacy technician working at a remote dispensing site pharmacy may not perform sterile or nonsterile compounding.

(12) This section does not alter the supervision requirements established in s. 465.014.

Section 5. Paragraph (c) of subsection (11) of section 465.022, Florida Statutes, is amended to read:

465.022 Pharmacies; general requirements; fees.—

(11) A permittee must notify the department of the

identity of the prescription department manager within 10 days after employment. The prescription department manager must comply with the following requirements:

(c) A Florida licensed ~~registered~~ pharmacist may not serve as the prescription department manager in more than one location unless approved by the board. However, a Florida licensed pharmacist may serve as a prescription department manager in more than one, but no more than two, remote dispensing site pharmacies, if such pharmacies are under common control.

Section 6. Subsection (1) of section 465.0265, Florida Statutes, is amended to read:

465.0265 Centralized prescription filling.—

(1) Except as otherwise provided in this chapter, a pharmacy licensed under this chapter may perform centralized prescription filling for another pharmacy, provided that the pharmacies have the same owner or have a written contract specifying the services to be provided by each pharmacy, the responsibilities of each pharmacy, and the manner in which the pharmacies will comply with federal and state laws, rules, and regulations.

Section 7. This act shall take effect July 1, 2018.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 751 Children, Families, & Seniors Subcommittee; Public Assistance
SPONSOR(S): Eagle
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	9 Y, 2 N, As CS	Langston	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida's Temporary Cash Assistance (TCA) Program provides cash assistance to needy families with children that meet eligibility requirements. To be eligible for full-family TCA, applicants must participate in work activities unless they qualify for an exemption. The regional workforce boards support and monitor applicants' compliance with work activity requirements. The Department of Children and Families (DCF) may sanction TCA recipients who fail to meet work activity requirements by withholding cash assistance for a specified minimum time or until the participant complies, whichever is later. The sanctions are either full-family (where no members of the noncompliant recipient's family may receive TCA) or allow child–only TCA (where any children under 16 may continue to receive TCA). In Florida, TCA and other social welfare benefits are placed on electronic benefits transfer (EBT) cards. Currently, DCF does not charge a fee for replacement EBT cards, although federal regulations allow such fees under certain conditions.

HB 751 increases the penalties for the first three instances of noncompliance with the TCA work requirements to align with the food assistance program's sanctions and creates a fourth sanction. The bill:

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

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

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

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

The bill has a recurring, positive fiscal impact of $4,428,430 from TCA benefit reductions for participant noncompliance, and $188,840 in fees for EBT card replacements, on DCF. The bill has a nonrecurring, negative fiscal impact of $952,360 to implement changes to the TCA program and EBT card system, on DCF.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Temporary Assistance for Needy Families (TANF)

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

Florida's Temporary Cash Assistance Program

The Temporary Cash Assistance (TCA) Program, administered by the Department of Children and Families (DCF), provides cash assistance to families with children under the age of 18 or under age 19[1] if full time secondary school students, that meet the technical, income, and asset requirements. The purpose of the TCA Program is to help families become self-supporting while allowing children to remain in their own homes. In October 2017, 11,757 adults and 65,133 children received TCA.[2]

Full-Family and Child-Only TCA

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

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

The majority of cash assistance benefits are child-only, through the relative caregiver program, or to work-eligible cases where the adult is ineligible due to sanction for failure to meet TCA work requirements. In October 2017, 35,753 of the 47,013 families receiving TCA were child-only cases; many of these families are not subject to work requirements.[5] In October 2017, there were 11,260 families receiving TCA through full-family cases containing an adult, 380 of which were two-parent families; these families are subject to work requirements.[6]

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[1] Parents, children and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.
[2] Department of Children and Families, Monthly Flash Report Caseload Data: October 2017, http://www.dcf.state.fl.us/programs/access/reports/flash2005.xlsx (last visited January 11, 2018).
[3] Grandparents or other relatives receiving child-only payments are not subject to the TANF work requirement or the TANF time limit.
[4] Child-only families also include situations where a parent is receiving federal Supplemental Security Income (SSI) payments, situations where the parent is not a U.S. citizen and is ineligible for TCA due to their immigration status, and situations where the parent has been sanctioned for noncompliance with work requirements.
[5] *Supra*, note 2.
[6] Id.

Administration

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

Eligibility Determination

An applicant must meet all eligibility requirements to receive TCA benefits. In order to be eligible, an applicant's gross family income must be 185 percent or less of the federal poverty level[8] and may not have more than $2,000 of counted liquid and nonliquid resources.[9] DCF processes the initial application for TANF. The applicant may submit his or her application in person, online or through the mail. DCF then determines an applicant's eligibility. To be eligible for full-family TCA, applicants must participate in work activities unless they qualify for an exemption.

Exemptions from the work requirement are available for:

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

If no exemptions from work requirements apply, DCF refers the applicant to DEO.[10] Upon referral, the participant must complete an in-take application and undergo assessment by RWB staff which includes:

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

Once the assessment is complete, the staff member and participant create an individual responsibility plan (IRP). The IRP includes:

- The participant's employment goal;
- The participant's assigned activities;
- Services provided through program partners, community agencies and the workforce system;

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[7] S. 445.007(13), F.S.
[8] S. 414.085(1)(a), F.S.
[9] Licensed vehicles with a combined value of $8,500 are excluded. S. 414.075, F.S.
[10] This is an electronic referral through a system interface between DCF's computer system and DEO's computer system. Once the referral has been entered into the DEO system, the information may be accessed by any of the RWBs or One-Stop Career Centers.

- The weekly number of hours the participant is expected to complete; and
- Completion dates and deadlines for particular activities.

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

TCA Income Limit and Maximum Benefit[11]

Household Size	Maximum Monthly Income (185% FPL)	Maximum Monthly Benefit, If Shelter Obligation > $50	Maximum Monthly Benefit, If Shelter Obligation ≤ $50	Maximum Monthly Benefit, If No Shelter Obligation
1	$1860	$180	$153	$95
2	$2504	$241	$205	$158
4	$3793	$364	$309	$254

Work Requirement

Individuals receiving TCA who are not otherwise exempt from work activity requirements must participate in work activities for the maximum number of hours allowable under federal law.[12] The number of required work or activities hours is determined by calculating the value of the cash benefits and then dividing that number by the hourly minimum wage amount.

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

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

Pursuant to federal rule[13] and state law,[14] the following activities may be used individually or in combination to satisfy the work requirements for a participant in the TCA program:

- Unsubsidized employment.
- Subsidized private sector employment.
- Subsidized public sector employment.
- On-the-job training.
- Community service programs.
- Work experience.
- Job search and job readiness assistance.
- Vocational educational training.
- Job skills training directly related to employment.
- Education directly related to employment.
- Attendance at school or course of study for graduate equivalency diploma.
- Providing child care services.[15]

[11] Email from Lindsey Zander, Deputy Legislative Affairs Director, Department of Children and Families, RE: HB 751 Question (Jan. 12, 2018) (on file with Children, Families, and Seniors Subcommittee staff).
[12] S. 445.024(2), F.S.
[13] 45 C.F.R. § 261.30
[14] S. 445.024, F.S.
[15] S. 445.024(1)(a)-(l), F.S.

RWBs currently have discretion to assign an applicant to a work activity, including job search, before receiving TCA. Some RWBs already require applicants to complete an initial job search as part of the application process.[16] Currently, Florida's TANF Work Verification Plan[17] requires participants to record each on-site job contact and a representative of the employer or RWB provider staff to certify the validity of the log by signing each entry. If the applicant conducts a job search by phone or internet, the activity must be recorded on a job search report form and include detailed, specific information to allow follow-up and verification by the RWB provider staff.[18]

The federal Administration for Children and Families requires states to meet work participation rates for the TCA program; the required rates vary by family type and state.[19] Florida must meet federal work participation rates for two categories of TCA families: (1) all families, meaning all cash assistance families with any work-eligible recipient(s) and (2) two-parent families with a work-eligible individual.[20] Nationally, the target participation rates are 50% of all families and 90% of two-parent families; these rates are adjusted based on caseload reduction credits, earned by reducing TCA caseloads and spending state funds in excess of required levels.[21] States that do not meet their required rates may be penalized; for at least the past three federal fiscal years, Florida has exceeded its required work participation rates.[22]

Sanctions for Noncompliance

RWBs can sanction TANF recipients who fail to comply with the work requirements by withholding cash assistance for a specified time, which lengthens with repeated lack of compliance.[23] Sanctions for non-compliant participants involve processes at both DEO and DCF. Because DEO administers the work programs, the RWB first becomes aware of participants' noncompliance and then notifies DCF to request a sanction; DCF then applies the sanctions.[24]

When a participant fails to comply with a mandatory work activity, the RWB records the non-compliance in DEO's tracking system and sends the recipient a notice of adverse action; the recipient then has 10 days to contact DEO to show good cause[25] for missing the requirement.[26] During the 10-day period, the RWB must make both oral and written attempts to contact the participant to:[27]

- 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;

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[16] Department of Children and Families, Agency Analysis of 2016 House Bill 563 (Nov. 20, 2015)(on file with Children, Families, and Seniors Subcommittee staff).
[17] DEPARTMENT OF CHILDREN AND FAMILIES ECONOMIC SELF-SUFFICIENCY PROGRAM OFFICE, *Temporary Assistance for Needy Families State Plan Renewal October 1, 2014 – September 30, 2017*, Nov. 14, 2014, available at www.dcf.state.fl.us/programs/access/docs/TANF-Plan.pdf (last visited January 10, 2018).
[18] *Supra*, note 16 at 2.
[19] OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY, *Mandatory Work Requirements for Recipients of the Food Assistance and Cash Assistance Programs*, page 4, (Jan. 8, 2018)(on file with the Children Families and Seniors Subcommittee staff).
[20] Id. at 5.
[21] Id.
[22] Id. at 4. DCF and DEO also report state fiscal year cash assistance work participation rates; however, these calculated rates differ from the federally calculated rates.
[23] Id. at 11.
[24] Id.
[25] Id. DCF captures limited information regarding good-cause for noncompliance in three categories: temporary illness, household emergency, and temporary transportation unavailable.
[26] Id. at 11, *see also* rule 65A-4.205(3), F.A.C.
[27] Rule 65A-4.205(3), F.A.C.

- Provide information transitional benefits if the participant subsequently obtained employment; and
- Make sure the participant understands that compliance with work activity[28] during 10-day period will avoid the imposition of a sanction.

If the recipient complies within 10 days, the RWB does not request a sanction. However, if the recipient does not show good cause to the RWB and does not comply, the RWB sends DCF a sanction request.[29] Once DCF receives the sanction request from the RWB, it then sends the recipient a notice of intent to sanction.[30] If the recipient does not show good cause within 10 days, the recipient is sanctioned by DCF, and DCF notifies DEO.[31]

Section 414.065(4), F.S., provides that noncompliance related to the following shall constitute exceptions to the penalties for noncompliance with work participation requirements:

- Unavailability of child care in certain circumstances;[32]
- Treatment or remediation of past effects of domestic violence;
- Medical incapacity;
- Outpatient mental health or substance abuse treatment; and
- Decision pending for Supplemental Security Income or Social Security Disability Income.

Section 414.065(4)(g), F.S., grants rulemaking authority to DCF to determine other situations that would constitute good cause for noncompliance with work participation requirements. It specifies that these situations must include caring for a disabled family member when the need for the care has been verified and alternate care is not available.[33] DCF adopted rules stating that other good causes for noncompliance include the temporary inability to participate due to circumstances beyond the participant's control, such as:

- A family emergency due to the inability to find suitable child care for a sick child under age 12;
- Hospitalization, medical emergency or death of an immediate family member;
- Natural disaster;
- Lack of transportation; and
- Court appearance.[34]

In its database, DEO classifies the reasons for sanctions for noncompliance in the following categories:[35]

- Failure to respond to a mandatory letter. [36] Typically, this is the letter recipients receive from DEO upon referral from DCF requiring them to register with DEO.
- Failure to attend a work activity.

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[28] The RWB 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.
[29] *Supra*, note 19 DCF only receives a request for sanction and not the reasons for the sanction. *See also* rule 65A-4.205(4), F.A.C.
[30] Id. at 11.
[31] Id., *see also* rule 65A-4.205(4), F.A.C
[32] 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 RWB an inability to obtain needed child care for one or more of the following reasons, as defined in the Child Care and Development 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 arrangements; or (3) the unavailability of appropriate and affordable formal child care arrangements. S. 414.065(4)(a), F.S.
[33] S. 414.065(4)(g), F.S.,
[34] Rule 65A-4.205(2), F.A.C.
[35] *Supra*, note 19 at 19.
[36] Id. at 18. For work-eligible individuals with at least one sanction in FFY 2017, over half the sanctions were for failure to respond to a mandatory letter in 14 of 24 RWBs.

- Failure to turn in a timesheet.
- Failure to attend training.
- Failure to turn in necessary documentation.

The consequences of sanctions are as follows:[37]

- 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.

From November 2016 through September 2017, the number of TCA families sanctioned for noncompliance with the work requirements breaks down as follows:

- 16,444 families were sanctioned for a first instance of non-compliance; 5,311, or 32.3 percent, of those families complied with work requirements to be reinstated in the program.[38]
- 4,806 families were sanctioned for a second instance of non-compliance; 2,229, or 46.4 percent, of those families complied with the work requirements to be reinstated in the program. An estimated 1,346 children continued to receive benefits through child-only case.[39]
- 2,954 families were sanctioned for a third instance of non-compliance; 1,273, or 43.1 percent, of those families complied with the work requirements to be reinstated in the program. An estimated 767 children in these families continued to receive benefits through child only cases.[40]

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.[41]

However, if a previously sanctioned participant fully complies with work activity requirements for at least six months, the participant must be reinstated as being in full compliance with program requirements for purpose of sanctions imposed under this section.[42] Once the participant has been reinstated, a subsequent instance of noncompliance would be treated as the first violation.

TCA Sanctions Compared to Supplemental Nutrition Assistance Program Sanctions

The Food Assistance Program, Supplemental Nutrition Assistance Program (SNAP), formerly called food stamps, also contains similar sanctions for failure to comply with its Employment and Training Program. However, the SNAP sanctions are a longer duration. For the first instance of noncompliance, food assistance benefits are terminated for one month or until compliance, whichever is later; for the second instance, food assistance benefits are terminated for three months or until compliance, whichever is later; and for the third instance, food assistance benefits are terminated for six months or until compliance, whichever is longer.[43]

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[37] S. 414.065(1), F.S.
[38] *Supra*, note 11.
[39] Id.
[40] Id.
[41] S. 414.065(2), F.S.
[42] S. 414.065(1), F.S.
[43] Rule 65A-1.605(3), F.A.C.

Electronic Benefits Transfer Card Program

Electronic benefits transfer (EBT) is an electronic system that allows a recipient to authorize transfer of their government benefits, including from the SNAP and TCA programs, to a retailer account to pay for products received.[44] The EBT card program is administered on the federal level by the Food and Nutrition Service (FNS) within the United States Department of Agriculture and at the state level by DCF.

In Florida, benefits are deposited into a TCA or SNAP account each month; the benefits in the TCA or SNAP account are accessed using the Florida EBT Automated Community Connection to Economic Self Sufficiency (ACCESS) card.[45] Even though the EBT card is issued in the name of an applicant, any eligible member of the household is allowed to use the EBT card.[46] Additionally, recipients may designate an authorized representative as a secondary cardholder who can receive an EBT card and access the food assistance account. Authorized representatives are often someone responsible for caring for the recipient. The ACCESS Florida system allows recipients to designate one authorized representative per household.

Prohibited Usage

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

- Any liquor store;
- Any casino, gambling casino, or gaming establishment; or
- Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.[47]

In 2013, Florida enacted legislation[48] that prohibits EBT cards from being accepted at the following locations or for the following activities:

- The purchase of an alcoholic beverage as defined in s. 561.01, F.S., and sold pursuant to the Florida Beverage Law.
- An adult entertainment establishment, as defined in s. 847.001, F.S.;
- A pari-mutuel facility, as defined in s. 550.02, F.S.;
- A slot machine facility, as defined in s. 551.102, F.S.;
- A commercial bingo facility that operates outside the provisions of s. 849.0931, F.S.; and
- A casino, gaming facility, or Internet café, including gaming activities authorized under part II of chapter 285.[49]

EBT Card Replacement

When a recipient loses an EBT card, he or she must call the EBT vendor's customer service telephone number to request a replacement EBT card.[50] The vendor then deactivates the card, and sends the

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[44] U.S. DEPARTMENT OF AGRICULTURE, FOOD AND NUTRITION SERVICES, *EBT: General Electronic Benefit Transfer (EBT) Information*, http://www.fns.usda.gov/ebt/general-electronic-benefit-transfer-ebt-information (last visited March 24, 2017).
[45] DEPARTMENT OF CHILDREN AND FAMILIES, *Welcome to EBT*, http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/welcome-ebt (last visited March 24, 2017).
[46] 7 C.F.R. § 273.2(n)(3).
[47] P.L. 112-96, Section 4004.
[48] S. 1, chapter 2013-88, Laws of Florida.
[49] S. 402.82(4), F.S.
[50] The Florida Legislature's Office of Program Policy Analysis & Government Accountability, *Supplemental Nutrition Assistance Program: DCF Has Mechanisms in Place to Facilitate Eligibility, Verify Participant Identity, and Monitor Benefit Use*, Dec. 3, 2015, p. 8 (research memorandum on file with Children, Families, and Seniors Subcommittee staff).

household a new card.[51] Federal regulations allow recipients to request an unlimited number of replacement EBT cards.[52] While states cannot limit the number of replacement cards, frequent requests for replacement cards can be an indicator of EBT card fraud, such as trafficking, which occurs when an EBT card containing benefits is exchanged for cash. FNS and DCF consider multiple replacement cards a preliminary indicator of trafficking.

FNS aims to preserve food assistance access for vulnerable populations (e.g., mentally ill and homeless people) who are at risk of losing their cards but who are not committing fraud,[53] while preventing others from trafficking and replacing their EBT cards. In the interest of preventing fraud, FNS regulations require states to monitor all client requests for EBT card replacements and send a notice, upon the fourth request in a 12-month period, alerting the household that their account is being monitored for potential suspicious activity.[54]

In Fiscal Year 2014-15, DCF sent 13,967 letters to households that had requested four or more cards.[55] The letter informs the recipient that the card does not need to be replaced each month and that it is important to keep track of the card.[56] The letter also informs the recipient that this number of replacement requests is not normal and that the household's EBT behavior is being monitored.[57] Additionally, in Fiscal Year 2014-15, less than one-third of the households who requested four cards (4,653 households) requested yet another replacement card after receiving the letter, and the DCF Office of Public Benefits Integrity referred these cases to the Department of Financial Services Division of Public Assistance Fraud (DPAF) for potential fraud investigation.[58]

Federal regulations allow states to charge recipients for the cost to replace an excessive[59] number of cards. FNS allows states to charge for the cost of the EBT card after four replaced cards. Under DCF's EBT contract, the vendor reports that replacements costs $3.50 per card.[60] A number of other states that charge for replacement cards. Those states charge between $2.00 to $5.00[61] per replacement card with some exceptions for good cause or financial hardship.

Effect of the Bill

Temporary Cash Assistance

Sanctions for Noncompliance

HB 751 increases the sanctions for TCA recipients subject to work requirements for the first three instances of noncompliance and creates a sanction for the fourth instance of noncompliance. The bill amends s. 414.065(1) and (2), F.S., to:

- Increase the first sanction from 10 days to one month or until compliance, whichever is later; and provides that child-only TCA is exempt from the first month of this sanction.
- Increase the second sanction from one month or until compliance, whichever is later, to three months or until compliance, whichever is later; and provides that child-only TCA, for children in the family under 16 years old, is only available for the first three months of the sanction period even if the participant takes longer to comply.

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[51] Id.
[52] 7 C.F.R. § 276.4
[53] 7 C.F.R. § 274.6(b)(5)(iii).
[54] 7 C.F.R. § 274.6(b)(6); in Florida, after the EBT vendor provides a fourth replacement card to a household within a 12-month span, DCF sends a letter to the household.
[55] *Supra*, note 50.
[56] Id.
[57] Id.
[58] Id.
[59] Defined by federal regulation as in excess of four cards within a 12-month span.
[60] *Supra*, note 50.
[61] By way of example, Louisiana and Maryland charge $2.00, New Mexico charges $2.50, and Massachusetts charges $5.00.

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

Because the bill limits the period when a family can receive child-only TCA following noncompliance, it may provide an additional incentive for noncompliant households to comply with work activities once they have served the minimum penalty period.[62]

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

Work Plan

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

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

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

EBT Cards

Prohibited Usage

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

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

Replacement Fee

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

[62] Department of Children and Families, Agency Analysis of 2018 House Bill 751, p. 7 (Nov. 30, 2017)(on file with Children, Families, and Seniors Subcommittee staff).

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

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Amends s. 414.069, F.S., relating to noncompliance with work requirements.
Section 2: Amends s. 445.024, F.S., relating to work requirements.
Section 3: Amends s. 402.82, F.S., relating to electronic benefits transfer program.
Section 4: Provides an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill increases the length of time during which TCA recipients are ineligible for benefits when not meeting the program's work requirements. The bill expands three existing penalty periods and creates a new fourth period. It is expected that these provisions will decrease recurring state expenditures for temporary cash assistance in the amount of $4,428,430.[63]

   In addition to the enhanced penalties, the bill imposes a fee for a fifth, and subsequent, replacement EBT card(s) within a 12-month period and provides such fee may be deducted from the participant's TCA benefits. The total, annual amount of such fees is estimated to be $188,840 and will result in state savings since it will be deducted from the cash assistance recipient's benefits. One-time programming modifications to DCF's public benefits disbursement system are expected to cost $952,360.[64]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

DCF may charge the costs of replacement cards against an EBT cardholder's benefits. The cardholder's benefits will be reduced by the cost to replace his or her EBT card. Assuming a replacement cost of $5.00 per card, the estimated card replacement fees recouped could approach

[63] Id. at p. 6.
[64] Id.

$188,840 based on replacing 37,768 cards.[65] Fee collections could diminish as the new process affects customer behaviors.[66]

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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 17, 2018, the Children, Families, and Seniors Subcommittee adopted an amendment that corrected a conflict between provisions of the bill to clarify that TCA may be continued though a protective payee for children under age 16 whose caregiver has been sanctioned for a first instance of noncompliance. The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

[65] Id.
[66] Id.

A bill to be entitled

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

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

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

414.065 Noncompliance with work requirements.—

(1) PENALTIES FOR NONPARTICIPATION IN WORK REQUIREMENTS AND FAILURE TO COMPLY WITH ALTERNATIVE REQUIREMENT PLANS.—The department shall establish procedures for administering penalties for nonparticipation in work requirements and failure to comply with the alternative requirement plan. If an individual in a family receiving temporary cash assistance fails to engage in work activities required in accordance with s. 445.024, the following penalties shall apply. Prior to the imposition of a sanction, the participant shall be notified orally or in writing that the participant is subject to sanction and that action will be taken to impose the sanction unless the participant complies with the work activity requirements. The participant shall be counseled as to the consequences of noncompliance and, if appropriate, shall be referred for services that could assist the participant to fully comply with program requirements. If the participant has good cause for noncompliance or demonstrates satisfactory compliance, the sanction may ~~shall~~ not be imposed. If the participant has subsequently obtained employment, the participant shall be

counseled regarding the transitional benefits that may be available and provided information about how to access such benefits. The department shall administer sanctions related to food assistance consistent with federal regulations.

(a)1. First noncompliance:

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

b. Temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first month of the penalty period through a protective payee as specified in subsection (2).

2. Second noncompliance:

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

b. Temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first 3 months of the penalty period through a protective payee as specified in subsection (2).

3. Third noncompliance:

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

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

4. Fourth noncompliance:

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

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

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

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

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

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

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

(2) CONTINUATION OF TEMPORARY CASH ASSISTANCE FOR

CHILDREN; PROTECTIVE PAYEES.—

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

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

445.024 Work requirements.—

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

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

1. What is expected of the participant to continue to receive temporary cash assistance benefits.

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

3. Potential penalties for noncompliance with the work requirements in s. 414.065, including how long benefits would be unavailable to the participant.

(b) Work with the participant to develop strategies to assist the participant in overcoming obstacles to compliance with the work requirements in s. 414.065.

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

402.82 Electronic benefits transfer program.—

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

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

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

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

(5) The department shall impose a fee for the fifth and each subsequent replacement electronic benefits transfer card that a participant requests within a 12-month period. The fee

must be equal to the cost of replacing the electronic benefits transfer card. The fee may be deducted from the participant's benefits. The department may waive the fee upon a showing of good cause, such as the malfunction of the card or extreme financial hardship.

Section 4. This act shall take effect July 1, 2018.

Amendment No. 1

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

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Eagle offered the following:

Amendment (with title amendment)

Remove lines 180-181 and insert:

Section 5. For fiscal year 2017-2018, the sum of $952,360 in nonrecurring funds from the Federal Grants Trust Fund is appropriated to the Department of Children and Families for the purpose of performing the technology modifications necessary to implement changes to the disbursement of temporary cash assistance benefits and the replacement of electronic benefits transfer cards pursuant to this act.

Amendment No. 1

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

Remove lines 24-25 and insert:

transfer cards under certain circumstances; providing an appropriation; providing an effective date.